

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14205

## CERTIFICATE OF DEATH

Reg. Dist. No.

14178

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>			
c. LENGTH OF STAY IN 1b <u>8 DAYS</u>				d. STREET ADDRESS <u>06X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>COUNTY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SADIE L AKERS</u>				4. DATE OF DEATH Month Day Year <u>DEC 10 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 30-1870</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>GEORGE AKERS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT Address <u>MRS CLYDE MORNINGSTAR NEW WINDSOR RURAL</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>450.0 Cordiac failure</u> DUE TO <u>Peripheral occlusion of vessels of left leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>1 week</u> years							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old fracture right hip</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 2, 1957</u> , to <u>Dec 10, 1959</u> , that I last saw the deceased alive on <u>Dec 9, 1959</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Stauffer</u>				ADDRESS (Street, city or town, state) <u>145 S. PROSPECT ST.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>JOHN C. STAUFFER</u>				HAGERSTOWN, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. H. Hartley &amp; Sons, New Windsor</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

14179

14206

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>3001-4</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hagerstown State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>300 Lyndhurst St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDGAR</b> Middle <b>JOSEPH</b> Last <b>ALLEN</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Contractor Own Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John T. Allen</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Connolly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 10 5672</b>	
17. INFORMANT <b>Mrs. Alice Allen</b>		Address <b>300 Lyndhurst St. Balto.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA BILATERAL</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>CORONARY ATHEROSCLEROSIS SEVERE</b> DUE TO (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OLD MYOCARDIAL INFARCTION, CHRONIC PYELONEPHRITIS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 29, 1959</b> to <b>DEC. 17, 1959</b> , that I last saw the deceased alive on <b>DEC. 17, 1959</b> , and that death occurred at <b>1:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George Beren</b>		ADDRESS (Street, city or town, state) <b>1500 PENNSYLVANIA AVE. BALTIMORE, MARYLAND.</b>	
PHYSICIAN'S NAME (Type) <b>DR. GEORGE BEREN</b>		DATE SIGNED <b>12/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29 Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>4101 E. Funeral Directors</b>		24a. REC'D BY REGISTRAR <b>DEC 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1908

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14180

14207

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>20 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>David Allen Baker</b>		4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 19, 1924</b>	9. AGE (In years last birthday) <b>35</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Concrete Finisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Building</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>Allen D. Baker</b>			14. MOTHER'S MAIDEN NAME <b>Mary Gossard</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W. W. 11</b>		16. SOCIAL SECURITY NO. <b>217-12-1658</b>		17. INFORMANT <b>Mrs. Betty M. Baker</b> Address <b>Hag. Rt. 5</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>825x</b> DUE TO <b>Fracture Skull</b> Conditions, if any, which gave rise to immediate cause (b) <b>fracture of skull</b> (c) <b>fracture of skull</b> cause lost.					INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Attempted to change driver without stopping car</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>6</b> a.m. <b>11-21-59</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b># 64-66</b>	20f. (City or town) <b>Hagerstown</b> (County) <b>Washington</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. E. W. Ditto Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12/14/59</b>	
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-15-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>River View Cemetery</b>		22d. LOCATION (City, town, or county) <b>Williamsport Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 17 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Washington

Bagatstown

Washington County Hospital

David

Allen

Hester

December

1932

Male

White

1912-1932

32

Concrete Finisher, House Building, Bagatstown, Md.

Allen D. Baker

Mary

Gossard

Yes

W. W. II

1912-1932 Mrs. Betty M. Baker

1912-1932

Dr. W. W. Dietz Jr.

1912-1932 River View Cemetery

Williamsport, Md.

George F. Harrison & Son, Bagatstown, Md.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 14181

14208

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 S. Cannon Ave.,				d. STREET ADDRESS 300 S. Cannon Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harry Samuel Baker				4. DATE OF DEATH Month 12 Day 24 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1903	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cab driver		10b. KIND OF BUSINESS OR INDUSTRY chauffeur		11. BIRTHPLACE (State or foreign country) Waynesboro, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Clinton Baker				14. MOTHER'S MAIDEN NAME Margaret Miner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-14-6484		17. INFORMANT Conrad E. Baker		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-24, 1959, to 12-24, 1959, that I last saw the deceased alive on 12-24, 1959, and that death occurred at 6:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Paul Harrison M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-27-59		22c. NAME OF CEMETERY OR CREMATORY Leitersburg Lutheran		22d. LOCATION (City, town, or county) (State) Leitersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE DEC 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hesser			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14209

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>FREDERICK</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>6 WK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>426 E. MAIN</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>MOSES BAUMGARDNER</b> Last 4. DATE OF DEATH Month <b>DEC</b> Day <b>6</b> Year <b>1959</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 2, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fruit grower</b>	
11. BIRTHPLACE (State or foreign country) <b>EMMITTSBURG, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Baumgardner</b>		14. MOTHER'S MAIDEN NAME <b>Nina Morrison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>W.W. 1</b>		16. SOCIAL SECURITY NO. <b>219-34-7448</b>	
17. INFORMANT <b>Mary H. Baumgardner</b>		Address <b>426 E. Main Emmitsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.V.A.</b> <b>456X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteritis</b> DUE TO (c) <b>temporal arteritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 days</b> <b>6 WKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>3</b> p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 14</b> , 19 <b>57</b> , to <b>Dec 6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 6</b> , 19 <b>59</b> , and that death occurred at <b>2:45</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>251 E. Baltimore St. Hagerstown, Md.</b> ACTUAL SIGNATURE <b>William W. Beckner Jr.</b> M.D. <b>251 E. Baltimore St. Hagerstown, Md.</b> PHYSICIAN'S NAME (Type) <b>William W. Beckner Jr.</b> <b>251 E. Baltimore St. Hagerstown, Md.</b>			
22b. DATE THEREOF <b>Dec. 9, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Frederick Co. Md.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>		ADDRESS <b>Emmitsburg, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14273

## CERTIFICATE OF DEATH

Reg. Dist. No.

14183

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Smithsburg #2</u>		c. LENGTH OF STAY IN 1b <u>45 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Smithsburg #2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Smithsburg #2</u>				d. STREET ADDRESS <u>Smithsburg #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Alice</u> Last <u>Blickenstaff</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1893</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Edgemont, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Luther Justice</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Stouffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Wilbur P. Blickenstaff, Smithsburg Md., #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>Arterio-sclerosis - Generalized, 10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 4</u> , 19 <u>59</u> , to <u>Dec 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>59</u> , and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Smithsburg Md</u> DATE SIGNED <u>12/5/59</u>							
ACTUAL SIGNATURE <u>G. A. K. Kohler</u>		M.D. <u>Smithsburg Md</u>					
PHYSICIAN'S NAME (Type) <u>G. A. K. Kohler</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Co. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove, Waynesboro Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

Vertical text labels on the right side of the form include:

- NAME OF DECEASED
- DATE OF DEATH
- PLACE OF DEATH
- CAUSE OF DEATH
- AGE
- SEX
- RACE
- EDUCATION
- OCCUPATION
- RELIGION
- DATE OF BIRTH
- PLACE OF BIRTH
- DATE OF DEATH
- PLACE OF DEATH
- CAUSE OF DEATH
- AGE
- SEX
- RACE
- EDUCATION
- OCCUPATION
- RELIGION
- DATE OF BIRTH
- PLACE OF BIRTH

The form is divided into several horizontal sections by lines, with some sections containing sub-headers. The text is printed in a serif font, and the overall layout is typical of a government-issued certificate.

## CERTIFICATE OF DEATH

Reg. Dist. No.

14184

14210

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>525 Gordon Circle</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VONNIE</b> Middle <b>LEGGETT</b> Last <b>BLOUNT</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 15, 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Plymouth, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Jackson Leggett</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Robertson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Gordon A. Lewis</b>		Address <b>525 Gordon Circle</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal Carcinomatosis</b> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
21. I certify that I attended the deceased from <b>1942</b> , 19____, to <b>12/14/59</b> , 19____, that I last saw the deceased alive on <b>12/13/59</b> , 19____, and that death occurred at <b>3:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 N. Potomac St. Hagerstown, Md.</b> DATE SIGNED <b>12/15/59</b> ACTUAL SIGNATURE <b>Searl Young</b> PHYSICIAN'S NAME (Type) <b>SEARL YOUNG MD.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/16/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. G. Hunt O.P.S.</b>		24. REC'D BY REGISTRAR <b>DEC 18 '59</b>	
25. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										14185	
14274											
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown RFD4</b>			c. LENGTH OF STAY IN 1b <b>26 yrs.</b>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown Md RFD #4</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cearfoss</b>					d. STREET ADDRESS <b>Cearfoss</b>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Amelia</b> Middle <b>V</b> Last <b>Boppe</b>					4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>19 59</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 18 1891</b>		9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Greensburg W. Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		
13. FATHER'S NAME <b>John Jacobs</b>					14. MOTHER'S MAIDEN NAME <b>Emily Ellen Price</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Cearfoss Md.</b> <b>Mr. Martin Luther Boppe Hagerstown RFD 4</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>General arteriosclerosis +</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Aug. 12</b> , 19 <b>58</b> , to <b>Dec. 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 10</b> , 19 <b>59</b> , and that death occurred at <b>2:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>212 W. Washington St Hagerstown</b> DATE SIGNED <b></b>											
ACTUAL SIGNATURE <b>Edward W. Ditto</b> M.D.			21a. REGISTRAR'S SIGNATURE <b>Edward W. Ditto III M.D.</b> <b>Hagerstown, Md</b>								
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Dec. 27-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. LaF Williamsport, Md</b>					24a. REC'D BY REGISTRAR DATE <b>DEC 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>				





## CERTIFICATE OF DEATH

Reg. Dist. No.

14186

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Franklin</b> Last <b>Bowers</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6 1901</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.	11. IF UNDER 24 HRS. Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Clearspring Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph Bowers</b>		14. MOTHER'S MAIDEN NAME <b>Mary Mills</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-28-3510</b>	
17. INFORMANT <b>Mrs. Anna Bowers</b>		18. ADDRESS <b>Pinesburg Williamsport Md RFD 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ATHEROSCLEROSIS OF THE CORONARY ARTERIES</b> DUE TO (c) <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PROSTATITIS, ACUTE DURATION ONE WEEK</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DECEMBER 16 19 59</b> to <b>DECEMBER 18 19 59</b> , that I last saw the deceased alive on <b>DECEMBER 18 19 59</b> , and that death occurred at <b>5.40 PM</b> . ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.			
PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D.</b> <b>CLEAR SPRING, MARYLAND</b> <b>12-19-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosehill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Clearspring Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert Leaf Williamsport, Md</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1116

CERTIFICATE OF DEATH

1116

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1. Name of deceased: [illegible]

2. Date of death: [illegible]

3. Place of death: [illegible]

4. Cause of death: [illegible]

5. Signature of physician: [illegible]

6. Signature of registrar: [illegible]

7. Date of registration: [illegible]

8. Place of registration: [illegible]

9. Name of registrar: [illegible]

10. Signature of registrar: [illegible]

11. Date of registration: [illegible]

12. Place of registration: [illegible]

13. Name of registrar: [illegible]

14. Signature of registrar: [illegible]

15. Date of registration: [illegible]

16. Place of registration: [illegible]

17. Name of registrar: [illegible]

18. Signature of registrar: [illegible]

19. Date of registration: [illegible]

20. Place of registration: [illegible]

21. Name of registrar: [illegible]

22. Signature of registrar: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No.

14187

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Mae</u> Last <u>Brashears</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Martin Hines</u>		14. MOTHER'S MAIDEN NAME <u>Zella Swain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Roger Brashears</u>		18. ADDRESS <u>216 W. Main Street Sharpsburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident - thrombosis or hem.</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intertrochanteric fracture of the left hip.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was dropped accidentally while being lifted into car</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9/27/59</u> p. m. <u>X</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Washington, D.C.</u>	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>12/12/59</u> , that I last saw the deceased alive on <u>12/12/59</u> , 19 <u>12/12/59</u> , and that death occurred at <u>1 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>12/14/59</u>			
ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D.		PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 15-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Wilkinsport, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the information required by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cases papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14213

## CERTIFICATE OF DEATH

14188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>10 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marshall Walter Brooks</b>				4. DATE OF DEATH Month Day Year <b>Dec 6 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 15 1878</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Vieter product</b>			
11. BIRTHPLACE (State or foreign country) <b>Shepherdstown, W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>George Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>Mrs Leah Branch</b>				Address <b>406 N. Jonathan St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis Gen</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Stroke years ago Prostatic hypertrophy</b> INTERVAL BETWEEN ONSET AND DEATH min <b>years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1954</b> , 19____, to <b>12-6-59</b> , 19____, that I last saw the deceased alive on <b>12-5-59</b> , 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 E. Antietam St.</b> DATE SIGNED <b>12-7-59</b> ACTUAL SIGNATURE <b>Louis G. Graff</b> M.D. PHYSICIAN'S NAME (Type) <b>Louis G. Graff, M.D.</b> <b>Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec 9 1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Watson</b>				ADDRESS <b>Hagerstown, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			





Director

14275

Item 14 FilmG253 12-10-59 et

# CERTIFICATE OF DEATH

Reg. Dist. No.

14189

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write name of city or nearest town) <b>BOONSBORO</b>		c. LENGTH OF STAY IN 1b <b>2 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LUTHER WADE BROOM</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/12/1905</b>
9. AGE (In years lost birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROPRIETOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>5 &amp; 10 STORE</b>	
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES R? BROOM</b>		14. MOTHER'S MAIDEN NAME <b>Martha Jane Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W. W. #2</b>	
17. INFORMANT <b>MR. EDWARD L. BROOM</b>		18. ADDRESS <b>BETHESDA MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cowdery Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>17 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 16, 1959</b> , to <b>Dec 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 4</b> , 19 <b>59</b> , and that death occurred at <b>4:30 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>21 N. MAIN ST. BOONSBORO, MD.</b> DATE SIGNED ACTUAL SIGNATURE <b>Joseph J. Seaton</b> PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hager</b>			

CERTIFICATE OF DEATH

1978

2

WIDE MOUTH

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Race: *White*

4. Date of Birth: *12/15/1925*

5. Date of Death: *10/10/1978*

6. Place of Birth: *New York, N.Y.*

7. Place of Death: *Home*

8. Cause of Death: *Heart Disease*

9. Duration of Illness: *2 Weeks*

10. Signature of Physician: *Dr. J. Smith*

11. Signature of Registrar: *John Doe*

12. Signature of Informant: *John Doe*

13. Date of Entry: *10/10/1978*

14. Time of Entry: *10:00 AM*

15. Signature of Informant: *John Doe*

16. Date of Entry: *10/10/1978*

17. Time of Entry: *10:00 AM*

18. Signature of Informant: *John Doe*

19. Date of Entry: *10/10/1978*

20. Time of Entry: *10:00 AM*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14276

## CERTIFICATE OF DEATH

14190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
c. LENGTH OF STAY IN 1b 5 yrs.		d. STREET ADDRESS 838 Maryland Ave.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie Byrum		4. DATE OF DEATH Month 12 Day 11 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Williamsport, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Andy Blair	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Elmer Byrum Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-1-59, to 12-11-59, that I last saw the deceased alive on 12-10-59, and that death occurred at 8 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. W. Kraiss		ADDRESS (Street, city or town, state) Hagerstown Md.	
DATE SIGNED 12-15-59		DATE SIGNED 12-15-59	
PHYSICIAN'S NAME (Type) FRED W. KRAISS		ADDRESS Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-14-59	
22c. NAME OF CEMETERY OR CREMATORY Funkstown		22d. LOCATION (City, town, or county) (State) Funkstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE DEC 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krauss	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

Form 100-10

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. RACE</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. SOCIAL SECURITY NUMBER</p> <p>12. MOTHER'S MARRIAGE LICENSE NUMBER</p> <p>13. DATE OF DEATH</p> <p>14. PLACE OF DEATH</p> <p>15. CAUSE OF DEATH</p> <p>16. MANNER OF DEATH</p> <p>17. SIGNATURE OF PHYSICIAN</p> <p>18. SIGNATURE OF REGISTRAR</p> <p>19. SIGNATURE OF WITNESS</p> <p>20. SIGNATURE OF DECEASED</p>		<p>21. COUNTY</p> <p>22. CITY</p> <p>23. STATE</p> <p>24. ZIP CODE</p> <p>25. COUNTY CLERK</p> <p>26. CITY CLERK</p> <p>27. STATE CLERK</p> <p>28. SIGNATURE OF DECEASED</p> <p>29. SIGNATURE OF PHYSICIAN</p> <p>30. SIGNATURE OF REGISTRAR</p> <p>31. SIGNATURE OF WITNESS</p> <p>32. SIGNATURE OF DECEASED</p> <p>33. SIGNATURE OF PHYSICIAN</p> <p>34. SIGNATURE OF REGISTRAR</p> <p>35. SIGNATURE OF WITNESS</p> <p>36. SIGNATURE OF DECEASED</p> <p>37. SIGNATURE OF PHYSICIAN</p> <p>38. SIGNATURE OF REGISTRAR</p> <p>39. SIGNATURE OF WITNESS</p> <p>40. SIGNATURE OF DECEASED</p> <p>41. SIGNATURE OF PHYSICIAN</p> <p>42. SIGNATURE OF REGISTRAR</p> <p>43. SIGNATURE OF WITNESS</p> <p>44. SIGNATURE OF DECEASED</p> <p>45. SIGNATURE OF PHYSICIAN</p> <p>46. SIGNATURE OF REGISTRAR</p> <p>47. SIGNATURE OF WITNESS</p> <p>48. SIGNATURE OF DECEASED</p> <p>49. SIGNATURE OF PHYSICIAN</p> <p>50. SIGNATURE OF REGISTRAR</p> <p>51. SIGNATURE OF WITNESS</p> <p>52. SIGNATURE OF DECEASED</p> <p>53. SIGNATURE OF PHYSICIAN</p> <p>54. SIGNATURE OF REGISTRAR</p> <p>55. SIGNATURE OF WITNESS</p> <p>56. SIGNATURE OF DECEASED</p> <p>57. SIGNATURE OF PHYSICIAN</p> <p>58. SIGNATURE OF REGISTRAR</p> <p>59. SIGNATURE OF WITNESS</p> <p>60. SIGNATURE OF DECEASED</p> <p>61. SIGNATURE OF PHYSICIAN</p> <p>62. SIGNATURE OF REGISTRAR</p> <p>63. SIGNATURE OF WITNESS</p> <p>64. SIGNATURE OF DECEASED</p> <p>65. SIGNATURE OF PHYSICIAN</p> <p>66. SIGNATURE OF REGISTRAR</p> <p>67. SIGNATURE OF WITNESS</p> <p>68. SIGNATURE OF DECEASED</p> <p>69. SIGNATURE OF PHYSICIAN</p> <p>70. SIGNATURE OF REGISTRAR</p> <p>71. SIGNATURE OF WITNESS</p> <p>72. SIGNATURE OF DECEASED</p> <p>73. SIGNATURE OF PHYSICIAN</p> <p>74. SIGNATURE OF REGISTRAR</p> <p>75. SIGNATURE OF WITNESS</p> <p>76. SIGNATURE OF DECEASED</p> <p>77. SIGNATURE OF PHYSICIAN</p> <p>78. SIGNATURE OF REGISTRAR</p> <p>79. SIGNATURE OF WITNESS</p> <p>80. SIGNATURE OF DECEASED</p> <p>81. SIGNATURE OF PHYSICIAN</p> <p>82. SIGNATURE OF REGISTRAR</p> <p>83. SIGNATURE OF WITNESS</p> <p>84. SIGNATURE OF DECEASED</p> <p>85. SIGNATURE OF PHYSICIAN</p> <p>86. SIGNATURE OF REGISTRAR</p> <p>87. SIGNATURE OF WITNESS</p> <p>88. SIGNATURE OF DECEASED</p> <p>89. SIGNATURE OF PHYSICIAN</p> <p>90. SIGNATURE OF REGISTRAR</p> <p>91. SIGNATURE OF WITNESS</p> <p>92. SIGNATURE OF DECEASED</p> <p>93. SIGNATURE OF PHYSICIAN</p> <p>94. SIGNATURE OF REGISTRAR</p> <p>95. SIGNATURE OF WITNESS</p> <p>96. SIGNATURE OF DECEASED</p> <p>97. SIGNATURE OF PHYSICIAN</p> <p>98. SIGNATURE OF REGISTRAR</p> <p>99. SIGNATURE OF WITNESS</p> <p>100. SIGNATURE OF DECEASED</p>
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14191

14214

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>725 Park Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BRENDA LEE CALANDRELLE</u>				4. DATE OF DEATH Month Day Year <u>December 23 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 23 1939</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mario A. Calandrelle</u>				14. MOTHER'S MAIDEN NAME <u>Betty Jane Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		INFORMANT Address <u>Mario A. Calandrelle 725 Park Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal anoxia</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Bilateral atelectasis</u> DUE TO (c) <u>min</u>				INTERVAL BETWEEN ONSET AND DEATH <u>min</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>- Club feet &amp; other congenital abnormalities</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/23</u> , 19 <u>59</u> , to <u>12/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>59</u> , and that death occurred at <u>12/25</u> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>119 E. Artisan 12/25/59</u> DATE SIGNED ACTUAL SIGNATURE <u>Louis G. Bruff</u> M.D. PHYSICIAN'S NAME (Type) <u>Louis G. BRUFF M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

CERTIFICATE OF DEATH

1912



*[Faint, mostly illegible handwritten text follows, likely containing personal and medical details of the deceased.]*



1  
Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14215

## CERTIFICATE OF DEATH

14192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Boyd</u> Last <u>Chrisman</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>9</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Abram Renner</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Adolphus W. Chrisman</u>		<u>Pinesburg Rd. Williamsport Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Intestinal Obstruction (partial)</u> DUE TO (c) <u>Adenocarcinoma sigmoid colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>1 mo.</u> <u>Unknown.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11.25.59</u> , 19 <u>59</u> , to <u>12.18.59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12.17.59</u> , 19 <u>59</u> , and that death occurred at <u>3.10A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 N. Potomac St., Hagerstown, Md.</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>Stearns Young</u>		M.D. <u>148 N. Potomac St., Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>S. Earl Young M.D.</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Near Clearspring Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith W. Reed</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 22 '59</u>	
ADDRESS <u>Blanche Williamsport</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										14193
Items 18&20 Filed 1-12-60 ams										14216
CERTIFICATE OF DEATH										Reg. Dist. No. 302
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>					d. STREET ADDRESS <u>1112 Broadway</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HARRISON CLIPP</u>					4. DATE OF DEATH Month Day Year <u>December 28 1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29 1874</u>		9. AGE (In years lost birthday) <u>85</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Leesburg Loudon Co Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John R. Clipp</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Hoffmaster</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-8925</u>		INFORMANT <u>Mrs Emma Clipp 112 Broadway Hagerstown</u>					Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia, shock</u> <u>903.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Fracture L hip</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Rt arm, Carcinoma Bladder, Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Dec 6/59</u> <u>Dec. 28/59</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on concrete driveway</u>								
20c. TIME OF INJURY Month, Day, Year <u>11:30 a.m. 12 6 19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Daughter's home</u>		20f. (City or town) <u>Hagerstown</u>		(County) (State) <u>Washington Maryland</u>		
21. I certify that I attended the deceased from <u>Dec 6</u> , 19 <u>59</u> , to <u>Dec 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>59</u> , and that death occurred at <u>7:25P</u> M, from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>Robt Vh Campbell</u>		M.D. <u>145 W Washington St</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>				DATE SIGNED <u>12/29/59</u>		
PHYSICIAN'S NAME (Type) <u>Robt V. H. Campbell</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>					24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			





1941

CERTIFICATE OF DEATH

20

Washington

1941

Washington County Hospital

DECEASED

White

John Thomas White

Washington County

1941

Washington County Hospital

John Thomas White

Washington, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14277

CERTIFICATE OF DEATH

Reg. Dist. No.

14195

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock Md.</b>		c. LENGTH OF STAY IN 1b <b>80 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Dorrier</b> Last <b>Dorrier</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25. 1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Fulton County Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hoffmad</b>		14. MOTHER'S MAIDEN NAME <b>Sophia Hebner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Henry W Dorrier</b>		Address <b>Rural 1 Hancock Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Ch. Nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 12, 1959</b> to <b>Dec 26, 1959</b> , that I last saw the deceased alive on <b>Dec 25, 1959</b> , and that death occurred at <b>1A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L.M. Shaffer</b>		DATE SIGNED <b>Dec 26, 1959</b>	
PHYSICIAN'S NAME (Type) <b>L.M. SHAFER M.D.</b>		ADDRESS (Street, city or town, state) <b>Hancock, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12.29.59</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Paul Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Near Hancock Washington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard F. Hume Hancock Md</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DEC 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



## CERTIFICATE OF DEATH

14196

Reg. Dist. No.

14218

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Conv. Home</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mercersburg, Pa.</b> 75X-3			
d. STREET ADDRESS <b>131 W. Seminary St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>L.</b> Last <b>ECKERT</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>20</b> Year <b>1959</b> 19			
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1859</b>		9. AGE (In years last birthday) <b>100</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>New York, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Carstens</b>				14. MOTHER'S MAIDEN NAME <b>Louisa Barning</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Edwin Hoffman, Mercersburg, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 1956</b> to <b>20 Dec 1959</b> , that I last saw the deceased alive on <b>20 Dec 1959</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F F Lusby</b>				ADDRESS (Street, city or town, state) <b>2301 Potomac St Hagerstown Md</b>		DATE SIGNED <b>21 Dec 59</b>	
PHYSICIAN'S NAME (Type) <b>F F Lusby</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Mercersburg, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John L. Luning</b>				ADDRESS <b>Mercersburg, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 31 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Mason</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

14219

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>WASH.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>3 HOURS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON CO. HOSPITAL</b>		/d. STREET ADDRESS <b>BLAIRS VALLEY</b>	
3. NAME OF DECEASED (Type or print) First <b>CYNTHIA</b> Middle <b>EICHELBERGER</b> Last <b>EICHELBERGER</b>		4. DATE OF DEATH Month <b>12</b> Day <b>4</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 4, 1959</b>
9. AGE (In years last birthday) yrs. <b>12</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>3</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT EICHELBERGER</b>		14. MOTHER'S MAIDEN NAME <b>DORTHY SWORD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
INFORMANT <b>ALBERT EICHELBERGER</b>		Address <b>CLEAR SPRING RT 2. MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature Birth</b> <b>761.5</b> DUE TO <b>6 1/2 months Gestation &amp; 3 1/2 lbs</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Premature separation of Placenta</b> (c) <b>2 hrs</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 4, 1959</b> to <b>Dec 4, 1959</b> that I last saw the deceased alive on <b>Dec 4, 1959</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Brewer</b>		ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b>	
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		DATE SIGNED <b>12/4/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BLAIRS VALLEY</b>		22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. CLARK</b>		ADDRESS <b>CLEAR SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Hulse</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

2081336XV2

CERTIFICATE OF DEATH

1921

W

Signature of Physician  
1/2 month's residence in Maryland  
Signature of Registrar

Signature of Coroner  
Signature of Registrar



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14198

Reg. Dist. No.

14220

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN 1b <b>3 WKS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MAUGANSVILLE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARLOCK MEM. CONV. HOME</b>				d. STREET ADDRESS <b>MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>IRENE</b> Last <b>ETHERIDGE</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/1877</b>		9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM E. NEWCOMER</b>				14. MOTHER'S MAIDEN NAME <b>SARANDA WINTERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. C.E. RIGGS</b>		<b>MAUGANSVILLE MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Congestion</b> <b>902.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) <b>Fracture Femur</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 years</b> <b>7 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall from bed to floor</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>1</b> am. <b>10-15</b> p.m. <b>1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Maugansville Washington Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. P. Little Jr</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>D. P. Little Jr</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/9/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM. PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horment, Hagerstown Md</b>				24a. REGD. BY REGISTRAR <b>DEC 8 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No. 14199

14221

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>JANE</b> Last <b>FACKLER</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>6</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Janua ry 13, 1980</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cigar Maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>		11. BIRTHPLACE (State or foreign country) <b>Gettysburg, Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Albert Fockler</b>				14. MOTHER'S MAIDEN NAME <b>Jessie Kate Clappsadle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>Mr. R. A. Knepper</b>				Address <b>326 Summit Ave. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Branchial Cyst</b> (c) <b>1 year</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 year</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12-2-59</b> , 19 <b>59</b> , to <b>12-6-1959</b> , that I last saw the deceased alive on <b>12-6-59</b> , 19 <b>59</b> , and that death occurred at <b>8 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. E. W. Ditt</b>				ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. E. W. DITT</b>				DATE SIGNED <b>12/6/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				ADDRESS <b>Wm. A. Hark</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 10 1959</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11

12321

CERTIFICATE OF DEATH

AND FORM STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Residence		Place of Birth	
Hagerstown		Hagerstown	
Date of Birth		Date of Death	
1900		1900	
Time of Death		Cause of Death	
10:00 AM		Heart Disease	
Place of Death		Place of Burial	
Hagerstown		Hagerstown	
Name of Physician		Name of Undertaker	
Dr. J. A. Kline		J. A. Kline	
Signature of Physician		Signature of Undertaker	
[Signature]		[Signature]	
Date of Certificate		Date of Burial	
1900		1900	
Time of Certificate		Time of Burial	
10:00 AM		10:00 AM	

1

Name of Deceased		Date of Death	
J. A. Kline		1900	
Place of Birth		Place of Death	
Hagerstown		Hagerstown	
Date of Birth		Date of Death	
1900		1900	
Time of Death		Cause of Death	
10:00 AM		Heart Disease	
Place of Death		Place of Burial	
Hagerstown		Hagerstown	
Name of Physician		Name of Undertaker	
Dr. J. A. Kline		J. A. Kline	
Signature of Physician		Signature of Undertaker	
[Signature]		[Signature]	
Date of Certificate		Date of Burial	
1900		1900	
Time of Certificate		Time of Burial	
10:00 AM		10:00 AM	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14222

## CERTIFICATE OF DEATH

Reg. Dist. No.

14200

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>5 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>38 Bryant Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Grayson</b> Last <b>Galt</b>		4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Naval Security</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Galt</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Platt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Joseph H. Eyler, Thurmont, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cerebral Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Colitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs 2 mos</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-1-1939</b> , to <b>12-1-39</b> , that I last saw the deceased alive on <b>11-30-39</b> , 19, and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md</b> DATE SIGNED <b>12/1/59</b>			
ACTUAL SIGNATURE <b>J. E. Dethlefsen</b> M.D.		PHYSICIAN'S NAME (Type) <b>J. E. Dethlefsen</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Piney Creek Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Taneytown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. O. Fuss &amp; Son</b> ADDRESS <b>Taneytown, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1 *X*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14201

14223  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>50 YRS.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) <b>39 RANDOLPH AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>139 RANDOLPH AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>ABNER</b> Middle <b>VICTOR</b> Last <b>MILLER GEARHART</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/1887</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED ASST. POSTMASTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARTIN J. GEARHART</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE WELTY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> (unknown) <input type="checkbox"/> (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. LEDA H. GEARHART</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinomatosis (primary in large bowel)</b> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 17, 19 56</b> to <b>Dec. 27, 19 59</b> that I last saw the deceased alive on <b>Dec. 27, 19 59</b> and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.A. Bell</b>		DATE SIGNED <b>119 North Potomac St. 12-28-59.</b>	
PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>		<b>Hagerstown, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. T. Hornum</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

CERTIFICATE OF DEATH

1933

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

Signature of Registrar

14224

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>HAROLD</u> Last <u>GERKINS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Gerkins</u>	
14. MOTHER'S MAIDEN NAME <u>Sadie</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>374-05-8764</u>		INFORMANT <u>Mrs. Eileen Einbinder</u> Address <u>Arlington, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs</u> <u>8 1/2 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 15</u> , 19 <u>55</u> , to <u>Dec 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>59</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Edgar J. Hoachlon</u> M.D.		ADDRESS (Street, city or town, state) <u>115 W. Wash. St. Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>E. Edgar J. Hoachlon</u>		DATE SIGNED <u>12/21/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-22-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Franklin Rieger</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1883

CERTIFICATE OF DEATH

302

Washington

Woman

Washington

Washington

D.O.B.

Washington

25 Mason Ave.

Washington County Hospital

CHARLES

HAROLD

CHARLES

29

Washington

March 2, 1903

White

Male

27

Lawrence, Maryland

Self-employed

in children

Radio

Machine

24-0-274 Mrs. Wilson Lindey, Washington, D.C.

24-0-274

*Handwritten notes:*  
This was a very young child.  
He was born in the hospital.  
He was very healthy and active.  
He was very intelligent and curious.  
He was very kind and gentle.  
He was very brave and courageous.  
He was very loyal and devoted.  
He was very honest and truthful.  
He was very generous and helpful.  
He was very brave and courageous.

Washington

Washington

March 2, 1903

Washington

Washington County Hospital

14225

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>D.O.A</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>813 Frederick Road</b>	
3. NAME OF DECEASED (Type or print) First <b>NAOMI</b> Middle <b>ELEANOR</b> Last <b>GLADHILL</b>				4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1897</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Baltimore City, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore City, Md</b>	
13. FATHER'S NAME <b>Thornton E. Saylor</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Riddle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Harvey W. Gladhill, 813 Frederick, Rd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Arterio Sclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hagerstown, Maryland</b>	
20f. (City or town) (County) (State) <b>Hagerstown, Maryland</b>				20g. (City or town) (County) (State) <b>Hagerstown, Maryland</b>			
21. I certify that I attended the deceased from <b>Dec 31, 1959</b> to <b>Jan 2, 1960</b> , that I last saw the deceased alive on <b>Dec 31, 1959</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J H Beachley</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown, Md</b>			
PHYSICIAN'S NAME (Type) <b>J H Beachley</b>				DATE SIGNED <b>Jan 2/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/3/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>				22e. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K Coffman</b>				ADDRESS <b>Hagerstown, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>				24c. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Blank certificate form with horizontal lines for text entry.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 14226  
 CERTIFICATE OF DEATH

14204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland Chronic Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary</b> First <b>Elizabeth</b> Middle <b>Gniazdowski</b> Last				4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 21, 1899</b>	
9. AGE (In years last birthday) <b>60</b>		10. AGE (In years last birthday) <b>60</b>		11. BIRTHPLACE (State or foreign country) <b>Laurel, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Leo W. Gniazdowski-3704 Yosemite Ave.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 442X DUE TO <b>Hypertensive Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 years</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov. 20, 1959</b> to <b>Dec 5, 1959</b> that I last saw the deceased alive on <b>Dec 5, 1959</b> , and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1500 Pennsylvania Ave. Hagerstown, Md.</b> DATE SIGNED <b>Dec 5, 1959</b> ACTUAL SIGNATURE <b>Young E. Chun</b> M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/8/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b> ADDRESS <b>Ellsworth Armacost-4600 Liberty Heights Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

091

1

1

CERTIFICATE OF DEATH

12220

Western Maryland State Hospital

Female White Born 1899

As home

Unknown

John W. Conner 1-3704 Tontonia Ave.

2 years

Heart failure (chronic) caused by

hypertension (chronic) caused by

arteriosclerosis (chronic) caused by

hypertension (chronic) caused by

arteriosclerosis (chronic) caused by

hypertension (chronic) caused by

arteriosclerosis (chronic) caused by

hypertension (chronic) caused by

arteriosclerosis (chronic) caused by

hypertension (chronic) caused by

arteriosclerosis (chronic) caused by

hypertension (chronic) caused by

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14278

CERTIFICATE OF DEATH

14205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Jefferson</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>8 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>E.</b> Last <b>Griffith</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>1.</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1886</b>
9. AGE (In years lost birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Berekly Co., W.Va.</b>	
11. BIRTHPLACE (State or foreign country) <b>Berekly Co., W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>W.Va.</b>	
13. FATHER'S NAME <b>Joseph T. Whittington</b>		14. MOTHER'S MAIDEN NAME <b>Alberta Whittington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Luther Griffith, Shenandoah J., W.V.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Uterus</b> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>9mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 10, 1959</b> to <b>Dec. 1, 1959</b> , that I last saw the deceased alive on <b>Dec. 1, 1959</b> , and that death occurred at <b>7:57 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b> DATE SIGNED <b>12/3/59</b>	
ACTUAL SIGNATURE <b>David R. Brewer</b>		M.D. <b>Clear Spring Md.</b>	
PHYSICIAN'S NAME (Type) <b>David Brewer</b>		<b>Clear Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>12-4-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Shepherdstown, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

Robert F. Minnich & Son, Hagerstown, Md.

partel 12-4-52 Maryland Cemetery

Shenandoah, N. Va.

Greenspring, Md.

David Brewer

partel 12-4-52 Maryland Cemetery

Shenandoah, N. Va.

partel 12-4-52 Maryland Cemetery

Shenandoah, N. Va.

partel 12-4-52 Maryland Cemetery

Shenandoah, N. Va.

partel 12-4-52 Maryland Cemetery

Shenandoah, N. Va.

partel 12-4-52 Maryland Cemetery

Shenandoah, N. Va.

partel 12-4-52 Maryland Cemetery

Shenandoah, N. Va.

partel 12-4-52 Maryland Cemetery

Shenandoah, N. Va.

14227

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>40 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Geary</b> Last <b>Grove</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>22</b> , Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 8, 1880</b>	
9. AGE (In years birth day) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Keedysville, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Mahlon Knadler</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Carr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-32-5196</b>			
17. INFORMANT <b>Homer C. Grove, Hagerstown, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO Years. Years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec. 21, 1959</b> to <b>Dec. 22, 1959</b> that I last saw the deceased alive on <b>Dec. 22, 1959</b> and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. A. Bell</i>				ADDRESS (Street, city or town, state) DATE SIGNED <b>119 North Potomac St. 12-23-59</b>			
PHYSICIAN'S NAME (Type) <b>R. A. Bell, M.D.</b>				Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>12-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Keedysville, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>				ADDRESS <b>119 North Potomac St.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

George F. Minahan & Son, Hagerstown, Md.  
Retail 11-24-22  
Hagerstown, Md.

Hagerstown, Md.



no 217-32-2190 Homer O. Grove, Hagerstown, Md.

Hagerstown, Md.

female white July 8, 1880 79

Misses Overy Grove Dec. 22, 19

Washington County Hospital

31 N. Locust St.

Hagerstown 40 years

Hagerstown

Washington

no.

Wash.

12237

CERTIFICATE OF DEATH

MARYLAND DEPARTMENT OF HEALTH



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14228

CERTIFICATE OF DEATH

Reg. Dist. No.

14207

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Genevieve Guessford</b>		4. DATE OF DEATH Month Day Year <b>December 25 1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 24, 1900</b>
9. AGE (In years last birthday) <b>59</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William McNeal</b>		14. MOTHER'S MAIDEN NAME <b>Hartman (maiden name)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-16-0988</b>	
17. INFORMANT <b>Charles W. Guessford, Leitersburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myeloid leukemia</b> <b>204.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>9 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 16</b> , 19 <b>59</b> , to <b>Dec. 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 25</b> , 19 <b>59</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Victor L. Ramos</b>		ADDRESS (Street, city or town, state) <b>Western Maryland State Hosp.</b>	
PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS</b>		DATE SIGNED <b>Dec. 25, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12-28-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

CERTIFICATE OF DEATH

1923

Washington

MA.

Washington

Leicesterburg

9 days

Hagerstown

Western Maryland State Hospital

Jan. 24, 1900

Female

Hagerstown, Md.

Housewife

( maiden name )  
Hagerstown

William H. Hager

213-10-0288 Charles W. Hagerford, Leicesterburg, Md.

No

12-25-59 Hagerburg Cemetery, Hagerstown, Md.

Robert E. Hagerford & Son, Hagerstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 18 Film 254 1-12-60 ams									
14229									
CERTIFICATE OF DEATH									
Reg. Dist. No. 14298									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>					d. STREET ADDRESS <u>Potomac Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Tawanna</u> Middle <u>Jean</u> Last <u>Guessford</u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1959</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 31 1952</u>		9. AGE (In years last birthday) yrs. <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Richard Guessford</u>					14. MOTHER'S MAIDEN NAME <u>Bernice Poole</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
INFORMANT <u>Mr. Richard Guessford</u> Address <u>Potomac St. Williamsport Md.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Blood loss</u> <u>510.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Artificial Blood from nose drainage</u> DUE TO (c) <u>T &amp; A operation 3 wks prior</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>August 1, 1958</u> to <u>December 29, 1959</u> that I last saw the deceased alive on <u>December 29, 1959</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>28 W. Potomac St</u> DATE SIGNED ACTUAL SIGNATURE <u>Max E. Byrkit</u> M.D. PHYSICIAN'S NAME (Type) <u>Max E. Byrkit, M.D.</u> <u>Williamsport, Md</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 1 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Williamsport Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u>						24a. REC'D BY REGISTRAR <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G253 12-21-59 et

## CERTIFICATE OF DEATH

14209

14230

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Fredrick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Sabillasville 10X-2</b>			
c. LENGTH OF STAY IN 1b <b>3 yrs.</b>				d. STREET ADDRESS <b>-----</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sutherly Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>A.</b> Last <b>Harbaugh</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1867</b>	9. AGE (In years day birth day) <b>92</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Simon W. Harbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Stanley Harbaugh</b> Address <b>Md Sabillasville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis &amp; Sinusitis</b> DUE TO (c) <b>indefinite</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July</b> , 19 <b>59</b> , to <b>death</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 12</b> , 19 <b>59</b> , and that death occurred at <b>7:10 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert F. Keadle</b> M.D. <b>Hagerstown, Md</b>				DATE SIGNED <b>12-14-59</b>			
PHYSICIAN'S NAME (Type) <b>Robert F. Keadle</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>United Brethern Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Greager</b> ADDRESS <b>Thurmont, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 17 59</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14210

14279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY IN 1b <u>22 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>REEDER NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAUL MARK HAYNES</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER 26 - 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED STONE AND BRICK MASON BLDG. INDUSTRY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ROHRERSVILLE WASH. CO. MD.</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>DAVID C. HAYNES</u>				14. MOTHER'S MAIDEN NAME <u>CLAIRA POFFENBERGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-09-9532</u>			
17. INFORMANT <u>MRS. ETHEL HAYNES ROHRERSVILLE MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Congestive heart failure</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>3 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>12-26-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-24-</u> , 19 <u>59</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>21 N. Main St., Boonsboro, Md</u> DATE SIGNED <u>12/26</u> ACTUAL SIGNATURE <u>Joseph Secundari</u> PHYSICIAN'S NAME (Type) <u>Joseph Secundari</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>DEC. 28, 1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ROHRERSVILLE CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>ROHRERSVILLE WASH. CO. MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			
ADDRESS <u>Boonsboro MD</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 31 '59</u>			

CERTIFICATE OF DEATH

1927

1

1

DATE

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

MARRIAGE

EDUCATION

OCCUPATION

RESIDENCE

DECEASED

TESTED

SIGNED

WITNESSES

NOTARY

FILED

## CERTIFICATE OF DEATH

Reg. Dist. No.

14211

14231

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ALICE</b> Last <b>HECKER</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1959</b>
9. AGE (In years lost birthday) yrs. <b>7</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min. <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Paul L. Hecker</b>		14. MOTHER'S MAIDEN NAME <b>Sally Ann Hock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Mr. Paul L. Hecker</b>		Address <b>403 Ridge Ave. Hagerstown, Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.0 Atelectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>762.0</b> DUE TO (c) <b>762.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 22, 19 59</b> to <b>Dec 22, 19 59</b> that I last saw the deceased alive on <b>Dec 22, 19 59</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. H. Hoachlen</b>		ADDRESS (Street, city or town, state) <b>11th W. Wash.</b>	
PHYSICIAN'S NAME (Type) <b>E. H. Hoachlen</b>		DATE SIGNED <b>12/23/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

WILLIAM H. HANLEY, JR. 1000 Ridge Ave. Baltimore, Md.

WILLIAM H. HANLEY, JR. 1000 Ridge Ave. Baltimore, Md.

1000 Ridge Ave. Baltimore, Md.

1000 Ridge Ave. Baltimore, Md.

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1000 Ridge Ave. Baltimore, Md.

CERTIFICATE OF DEATH

Reg. Dist. No.

14212

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD T. HENESY</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER 9 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 27 1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>NEAR WILLIAMSPORT WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>			
13. FATHER'S NAME <u>THOMAS HENESY</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH RIPPLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-09-5425</u>			
17. INFORMANT <u>MRS. ROBERT J. HAMMOND</u>				Address <u>FAIRPLAY MD. 2131</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 241X DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic bronchial asthma</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 4, 1959</u> , to <u>November 9, 1959</u> , that I last saw the deceased alive on <u>November 9, 1959</u> , and that death occurred at <u>2 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. Leonard</u>				ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>			
PHYSICIAN'S NAME (Type) <u>John D. Boast</u>				M.D. <u>Boonsboro Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 12, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WILLIAMSPORT WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Boast</u>				ADDRESS <u>Boonsboro Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24a. REC'D BY REGISTRAR <u>DEC 15 '59</u>				DATE <u>DEC 15 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14232

CERTIFICATE OF DEATH

1971

1. Name of deceased: ELIZABETH J. BROWN

2. Sex: F

3. Date of birth: 10-15-1915

4. Place of birth: NEW YORK, N.Y.

5. Race: W

6. Marital status: M

7. Cause of death: HEART DISEASE

8. Date of death: 11-10-1971

9. Place of death: NEW YORK, N.Y.

10. Signature of physician: [Signature]

11. Signature of registrar: [Signature]

12. Date of registration: 11-15-1971

13. Place of registration: NEW YORK, N.Y.

14. Name of informant: JOHN B. BROWN

15. Address of informant: 1234 5th Ave., New York, N.Y.

16. Signature of informant: [Signature]

17. Date of interview: 11-12-1971

18. Name of interviewer: JOHN B. BROWN

19. Address of interviewer: 1234 5th Ave., New York, N.Y.

20. Signature of interviewer: [Signature]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14213

Reg. Dist. No.

14280

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Ringgold</u>		c. LENGTH OF STAY IN 1b <u>6 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural, Ringgold</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Smithsburg #1</u>				d. STREET ADDRESS <u>Smithsburg #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Arthur</u> Last <u>Hess</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1896</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grader Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Rouzeville Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hess</u>				14. MOTHER'S MAIDEN NAME <u>Emma Rouzer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-0851</u>		17. INFORMANT <u>Mrs. John A. Hess</u>		Address <u>Smithsburg Md., #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Ruptured Myocardial Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Recent</u>							INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DR E W DITTEL</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harbaugh's</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg #2, Franklin Co. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove, Waynesboro Pa.</u>				24a. REC'D BY REGISTRAR <u>DEC 9 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED _____		2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. AGE _____		4. RACE _____	
5. DATE OF DEATH _____		6. TIME OF DEATH _____	
7. PLACE OF DEATH _____		8. CAUSE OF DEATH _____	
9. MANNER OF DEATH _____		10. SIGNATURE OF MEDICAL EXAMINER _____	
11. SIGNATURE OF WITNESS _____		12. SIGNATURE OF DECEASED _____	
13. SIGNATURE OF DECEASED _____		14. SIGNATURE OF DECEASED _____	
15. SIGNATURE OF DECEASED _____		16. SIGNATURE OF DECEASED _____	
17. SIGNATURE OF DECEASED _____		18. SIGNATURE OF DECEASED _____	
19. SIGNATURE OF DECEASED _____		20. SIGNATURE OF DECEASED _____	
21. SIGNATURE OF DECEASED _____		22. SIGNATURE OF DECEASED _____	
23. SIGNATURE OF DECEASED _____		24. SIGNATURE OF DECEASED _____	
25. SIGNATURE OF DECEASED _____		26. SIGNATURE OF DECEASED _____	
27. SIGNATURE OF DECEASED _____		28. SIGNATURE OF DECEASED _____	
29. SIGNATURE OF DECEASED _____		30. SIGNATURE OF DECEASED _____	
31. SIGNATURE OF DECEASED _____		32. SIGNATURE OF DECEASED _____	
33. SIGNATURE OF DECEASED _____		34. SIGNATURE OF DECEASED _____	
35. SIGNATURE OF DECEASED _____		36. SIGNATURE OF DECEASED _____	
37. SIGNATURE OF DECEASED _____		38. SIGNATURE OF DECEASED _____	
39. SIGNATURE OF DECEASED _____		40. SIGNATURE OF DECEASED _____	
41. SIGNATURE OF DECEASED _____		42. SIGNATURE OF DECEASED _____	
43. SIGNATURE OF DECEASED _____		44. SIGNATURE OF DECEASED _____	
45. SIGNATURE OF DECEASED _____		46. SIGNATURE OF DECEASED _____	
47. SIGNATURE OF DECEASED _____		48. SIGNATURE OF DECEASED _____	
49. SIGNATURE OF DECEASED _____		50. SIGNATURE OF DECEASED _____	
51. SIGNATURE OF DECEASED _____		52. SIGNATURE OF DECEASED _____	
53. SIGNATURE OF DECEASED _____		54. SIGNATURE OF DECEASED _____	
55. SIGNATURE OF DECEASED _____		56. SIGNATURE OF DECEASED _____	
57. SIGNATURE OF DECEASED _____		58. SIGNATURE OF DECEASED _____	
59. SIGNATURE OF DECEASED _____		60. SIGNATURE OF DECEASED _____	
61. SIGNATURE OF DECEASED _____		62. SIGNATURE OF DECEASED _____	
63. SIGNATURE OF DECEASED _____		64. SIGNATURE OF DECEASED _____	
65. SIGNATURE OF DECEASED _____		66. SIGNATURE OF DECEASED _____	
67. SIGNATURE OF DECEASED _____		68. SIGNATURE OF DECEASED _____	
69. SIGNATURE OF DECEASED _____		70. SIGNATURE OF DECEASED _____	
71. SIGNATURE OF DECEASED _____		72. SIGNATURE OF DECEASED _____	
73. SIGNATURE OF DECEASED _____		74. SIGNATURE OF DECEASED _____	
75. SIGNATURE OF DECEASED _____		76. SIGNATURE OF DECEASED _____	
77. SIGNATURE OF DECEASED _____		78. SIGNATURE OF DECEASED _____	
79. SIGNATURE OF DECEASED _____		80. SIGNATURE OF DECEASED _____	
81. SIGNATURE OF DECEASED _____		82. SIGNATURE OF DECEASED _____	
83. SIGNATURE OF DECEASED _____		84. SIGNATURE OF DECEASED _____	
85. SIGNATURE OF DECEASED _____		86. SIGNATURE OF DECEASED _____	
87. SIGNATURE OF DECEASED _____		88. SIGNATURE OF DECEASED _____	
89. SIGNATURE OF DECEASED _____		90. SIGNATURE OF DECEASED _____	
91. SIGNATURE OF DECEASED _____		92. SIGNATURE OF DECEASED _____	
93. SIGNATURE OF DECEASED _____		94. SIGNATURE OF DECEASED _____	
95. SIGNATURE OF DECEASED _____		96. SIGNATURE OF DECEASED _____	
97. SIGNATURE OF DECEASED _____		98. SIGNATURE OF DECEASED _____	
99. SIGNATURE OF DECEASED _____		100. SIGNATURE OF DECEASED _____	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14214

14233

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>50 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>118 John St.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>V</b> Middle <b>Purcell</b> Last <b>Hill</b>				4. DATE OF DEATH Month <b>12</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 27, 1881</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinest</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>M.P?. Moller</b>		11. BIRTHPLACE (State or foreign country) <b>Jefferson Co. W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>V. Percy Hill Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Julia Trussel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-14-7178</b>		17. INFORMANT <b>D. Blanche Hill</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO <b>Generalized Arteriosclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma and Emphysema.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 29, 1959</b> to <b>Dec. 30, 1959</b> , that I last saw the deceased alive on <b>Dec. 29, 1959</b> and that death occurred at <b>7:00A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St. 12-30-59</b> DATE SIGNED							
ACTUAL SIGNATURE <b>R.A. Bell</b>				M.D. <b>Hagerstown, Maryland.</b>			
PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1-2-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> Address <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14281

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14215

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R. #6</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LESTER</b> Middle <b>W.</b> Last <b>HORNBAKER</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/11/23</b>	
9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home building</b>		11. BIRTHPLACE (State or foreign country) <b>Mercersburg, Pa., R.D.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Harry R. Hornbaker</b>				14. MOTHER'S MAIDEN NAME <b>Elsie M. Gordon</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes. 2/8/43 to 8/17/45</b>				16. SOCIAL SECURITY NO. <b>183-12-1757</b>			
17. INFORMANT <b>Mrs. Mary H. Hornbaker, Hagers-</b>				Address <b>town, Md. R. #6</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fractured Skull</b>							
DUE TO <b>823x</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Concussion Resulting in Hemorrhage</b>							
DUE TO <b>12 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car skidded on wet highway</b>			
20c. TIME OF INJURY Month, Day, Year <b>7 12-11-1959</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>R #60 3 mi out Hagerstown Washington Md</b>				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>H. E. W. D. T. To J.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H. E. W. D. T. To J.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>Hagerstown Md 12/15/59</b>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Mercersburg, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. M. Beringer</b>				ADDRESS <b>Mercersburg, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 17 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.







## CERTIFICATE OF DEATH

14216  
Reg. Dist. No. 302

14234

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>10 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JANE ELIZABETH HOSTETTER</u>				4. DATE OF DEATH Month Day Year <u>December 18 1959 19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 26 1881</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Mountaineer Fred. Co</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joseph Eaton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clem</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>314-09-0683</u>			
17. INFORMANT <u>Jane H. Smith</u> Address <u>917 Armstrong Ave Hagerstown Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>							
420.0 DUE TO <u>Arteriosclerotic Heart Disease</u>							
(b) <u>Generalized Arteriosclerosis</u>							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/12</u> , 19 <u>59</u> , to <u>12/18</u> , 19 <u>59</u> ; that I last saw the deceased alive on <u>12/17</u> , 19 <u>59</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Jennings</u>				ADDRESS (Street, city or town, state) <u>136 W. Washington St. Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George Jennings</u>				DATE SIGNED <u>12/18/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md. Wash Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

11211

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14235

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>weeks</b> <b>X</b> <b>Samples Manor (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>				d. STREET ADDRESS <b>1 Samples Manor Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ESTHER</b> Middle <b>Eulalia</b> Last <b>Houser</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>20</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 12, 1895</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hou sewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Samples Manor, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Tilghman Houser</b>				14. MOTHER'S MAIDEN NAME <b>Martha Jane Hanes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		INFORMANT <b>Charles H. Albright</b> <b>RD#1, Harpers Ferry, West Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>general carcinomatosis</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>carcinoma of breasts, bilateral</b> DUE TO (c) <b>6 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>14 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOVEMBER 12, 1959</b> , to <b>December 20, 1959</b> , that I lost sow the deceased olive on <b>December 20</b> , 19 <b>59</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)						DATE SIGNED	
ACTUAL SIGNATURE <b>Victor L. Ramos</b>				M.D. <b>Western Maryland State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>VICTOR L. Ramos</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Samples Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Donald Caskles</b>				ADDRESS <b>Harpers Ferry, W.Va.</b>		24a. REC'D BY REGISTRAR <b>DEC 23 59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. L. S. Hump</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

L901, SA.

1997

## CERTIFICATE OF DEATH

Reg. Dist. No.

14236

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>7 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BOONSBORO</u> d. STREET ADDRESS <u>1 ST. PAUL ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>VIOLA</u> Middle <u>CORDER</u> Last <u>HUTZELL</u>			4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>12</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 9-1894</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>3</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD. U.S.A.</u>	
13. FATHER'S NAME <u>HERBERT G. DAGENHART</u>			14. MOTHER'S MAIDEN NAME <u>MARTHA MADORAN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-10-3367</u> INFORMANT <u>HARVEY HUTZELL</u> Address <u>BOONSBORO MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> 331X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>59</u> , to <u>Dec 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 11</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>J. W. Levan</u>		ADDRESS (Street, city or town, state) <u>Boonsboro Md</u>		DATE SIGNED <u>12/13/59</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Levan</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>DEC. 14, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. East</u>		ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>	24c. DATE <u>DEC 18 '59</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14238

DECEASED  
NAME  
AGE  
SEX  
RACE  
DATE OF BIRTH  
PLACE OF BIRTH  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF REGISTRAR  
OFFICE OF THE REGISTRAR



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14219

CERTIFICATE OF DEATH

Reg. Dist. No. 302

14237

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OLGA</b> Middle <b>LENORA</b> Last <b>IRBY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 8, 1894</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Sharpsburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Reno Virginia Mose</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-12-1482</b>	
17. INFORMANT <b>Elijah Irby</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> DUE TO <b>Enterosclerotic Heart Disease</b> DUE TO <b>Anemia Secondary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 203x INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>2 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>0</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1935</b> , 19____, to <b>12/9/59</b> , 19____, that I last saw the deceased alive on <b>12/8/59</b> , 19____, and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>12/9/59</b>			
ACTUAL SIGNATURE <b>S. Earl Young</b>		PHYSICIAN'S NAME (Type) <b>S. Earl Young M.D. 148 N. Potomac St., Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/11/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DEC 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

14337

CERTIFICATE OF HEALTH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14220

Reg. Dist. No.

14238

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>151 West Washington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>STANLEY</b> <b>JESKIE</b>				4. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>24 March 1918</b>		9. AGE (In years last birthday) <b>41</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Ledwood, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Jeskie</b>				14. MOTHER'S MAIDEN NAME <b>Frances Candle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>7/31/41 -1959 234-26-7842</b>		17. INFORMANT Address <b>Capt. John Rose, Fort Ritchie, Cascade, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ATHEROSCLEROSIS SEVERE</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (b) <b>THROMBOTIC OCCLUSION CIRCUMFLEX ARTERY</b> (a), stating the underlying cause last. DUE TO (c) <b>RECENT</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>DR. F.W. DITTO, JR.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-25-59</b>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/31/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Buckhannon Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Buckhannon W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. Marlin Poe</b>				ADDRESS <b>Waynesboro, Penna.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 29 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

95527

## 14239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <u>Washington</u> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>929 Frederick Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MATTHEW</u> Middle <u>WILLIAM</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1959</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leonard Jones</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia (no Record)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-38-2701</u>	
17. INFORMANT <u>Mrs Minnie Kuhn Jones</u>		Address <u>929 Frederick Rd Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardio-Renal Disease</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. D. Jones</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. D. Jones</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF EXAMINER		12. DATE	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS		16. SIGNATURE OF WITNESS	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS	
29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS	
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37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
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45. SIGNATURE OF WITNESS		46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS	
53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS	
57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS	
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69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS		76. SIGNATURE OF WITNESS	
77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS		79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
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89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS		91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS	
93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14240

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

14222

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>857 Frederick Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE TYSON KENLY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1890</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farm Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Davies L. Kenly</b>		14. MOTHER'S MAIDEN NAME <b>Anna H. Towson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Robert G. Kenly</b> Address <b>New York City</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-28</b> , 19 <b>59</b> , to <b>12-16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-16</b> , 19 <b>59</b> , and that death occurred at <b>4 A-M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac st.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Cloyd A. Hoffman</b> M.D. PHYSICIAN'S NAME (Type) <b>Cloyd A. Hoffman</b> <b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/18/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14241

CERTIFICATE OF DEATH

Reg. Dist. No. 502

14223

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>50 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>28 No Mulberry St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>MAE</u> Last <u>KING</u>		4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stitcher Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Co</u>	11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Hiram King</u>	
14. MOTHER'S MAIDEN NAME <u>Malinda Mowen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>214-09-2183</u>		INFORMANT <u>Mrs Mary v King 28 No Mulberry St</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>  </u> , 19 <u>58</u> , to <u>25 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>25 Dec</u> , 19 <u>59</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. D. Wilson</u>		DATE SIGNED <u>12/26/59</u>	
PHYSICIAN'S NAME (Type) <u>J. D. WILSON, M.D.</u>		ADDRESS (Street, city or town, state) <u>135 NO POTOMAC ST HAGERSTOWN, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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CERTIFICATE OF DEATH

1981

IN THE CITY OF NEW YORK

CHIEF OF HEALTH

14222

## CERTIFICATE OF DEATH

Reg. Dist. No.

14224

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>35yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month <b>Dec</b> Day <b>18</b> Year <b>1959</b>				5. SEX <b>Male</b> 6. COLOR OR RACE <b>Colored</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>July 31 1908</b> 9. AGE (In years last birthday) <b>51</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Taverns</b>			
11. BIRTHPLACE (State or foreign country) <b>Shenandera, W.Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>George William</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Dorsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-14-5828</b>			
17. INFORMANT <b>Mrs. Iame Wilson</b>				Address <b>110 W. North St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>carcinoma of lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>5 mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 30, 1959</b> , to <b>Dec. 18, 1959</b> , that I last saw the deceased alive on <b>Dec. 18, 1959</b> , and that death occurred at <b>11:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Phyl C. Hoffman</b>				ADDRESS (Street, city or town, state) <b>214 N. Potomac St.</b>			
DATE SIGNED <b>12/20/59</b>							
PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 21 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John K. Watson</b>				ADDRESS <b>Hagerstown Md</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APPROXIMATELY 10% OF THE TOTAL POPULATION OF THE UNITED STATES IS REPORTED TO HAVE A HISTORY OF ALLERGIC REACTIONS. THE PREVALENCE OF ALLERGIC REACTIONS IS REPORTED TO BE HIGHER IN THE UNITED STATES THAN IN OTHER COUNTRIES. THE PREVALENCE OF ALLERGIC REACTIONS IS REPORTED TO BE HIGHER IN THE UNITED STATES THAN IN OTHER COUNTRIES.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14225

14243

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Silas</u> Middle <u>Ray</u> Last <u>Kline</u>		4. DATE OF DEATH Month <u>Dec. 12,</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19, 1900</u>
9. AGE (In years lost birthday) yrs. <u>59</u>		10. IF UNDER 1 YEAR Months <u>59</u> Days <u>59</u> Hours <u>59</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Pondsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Victor Kline</u>		14. MOTHER'S MAIDEN NAME <u>Ada J. Lumm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-36-1336</u>	
17. INFORMANT <u>Marshall B. Kline, Smithsburg, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-13-</u> , 19 <u>58</u> , to <u>12-12-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-11-</u> , 19 <u>59</u> , and that death occurred at <u>4:30 A.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Hess</u>		ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>12-14-59</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Dec. 16, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son, Smithsburg, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

STATE OF TENNESSEE  
DEPARTMENT OF REVENUE  
OFFICE OF THE COMMISSIONER  
MEMPHIS, TENNESSEE

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TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14226

14244

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 Mos</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Memorial Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> d. STREET ADDRESS <b>713 West Washington, St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALTA BELLE KRETZER</b>		4. DATE OF DEATH Month Day Year <b>December 30 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 6, 1890</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Alteration</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Leiter Bros</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>	
15. FATHER'S NAME <b>Jacob Owen Kretzer</b>		16. MOTHER'S MAIDEN NAME <b>Amanda E Biser</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		18. SOCIAL SECURITY NO. <b>214-09-0643</b>	
19. INFORMANT <b>Mrs Lorena Unseld</b>		20. Address <b>713 W. Washington St Hagerstown, Maryland</b>	
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Diabetes</b>		22. INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>indefinite</b>	
23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus, generalized arteriosclerosis</b>		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. MEDICAL CERTIFICATION 25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 25b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 25c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 25d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 25e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 25f. (City or town) (County) (State) <b>Hagerstown</b> <b>Washington</b> <b>MD</b>		26. I certify that I attended the deceased from <b>January 7, 19 59</b> to <b>death</b> , that I last saw the deceased alive on <b>Dec 15</b> , 19 <b>59</b> , and that death occurred at <b>3 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Hagerstown</b> <b>12-30-59</b>	
27. ACTUAL SIGNATURE <b>Bruce L. Caddle</b>		28. PHYSICIAN'S NAME (Type) <b>Bruce L. Caddle</b>	
29. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		30. DATE THEREOF <b>1/2/60</b>	
31. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		32. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash. Co., Md</b>	
33. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K Coffman</b>		34. ADDRESS <b>Hagerstown, Md</b>	
35. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		36. REGISTRAR'S SIGNATURE <b>Arthur S. Knepp</b>	



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14227

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>BALTIMORE, COUNTY MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN, MD.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (B)</b> 03-54-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>704 BAURENSCHMIDT DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>EVA</b> Middle <b>HUHN</b> Last <b>KRIETE</b>		4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 20, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM HUHN</b>		14. MOTHER'S MAIDEN NAME <b>ISABEL GIBSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>EDWIN KRIETE</b>		Address <b>704 BAURENSCHMIDT DRIVE (SON)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetic gangrene of leg post-amputation</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>6 days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis with cerebral arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 25, 1959</b> to <b>Dec 1, 1959</b> , that I last saw the deceased alive on <b>Nov 30, 1959</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John C. Stauffer</b>		ADDRESS (Street, city or town, state) <b>HAGERSTOWN, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>JOHN C. STAUFFER</b>		DATE SIGNED <b>12/1/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/4/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LORRRAINE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Smith</b>		ADDRESS <b>GLENBURNIE, MARYLAND</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	





## CERTIFICATE OF DEATH

Reg. Dist. No.

14282

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pt. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bonshorn</u>		c. LENGTH OF STAY IN tb <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Farmington-Roady Memorial Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>H.</u> Middle <u>Kruehn</u> Last		4. DATE OF DEATH <u>December 1</u> 19 <u>59</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 17, 1888</u> 9. AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Utility Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fulton Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Lewis Kruehn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anna Lages</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Robert Kruehn, Fulton Md.</u>	
17. INFORMANT <u>Robert Kruehn, Fulton Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.0</u> DUE TO (c) <u>6 months</u> INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 2</u> , 19 <u>59</u> , to <u>December 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 30</u> , 19 <u>59</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. W. W.</u> M.D.		ADDRESS (Street, city or town, state) <u>Bonshorn, Md.</u> DATE SIGNED <u>12/11/59</u>	
PHYSICIAN'S NAME (Type) <u>G. W. Healy</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Fulton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Sanderson Laurel Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DEC 7 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

File 244-100

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>		<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>		<p>15. SIGNATURE OF NEXT OF KIN</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF DECEASED</p>		<p>19. SIGNATURE OF NEXT OF KIN</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF NEXT OF KIN</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF NEXT OF KIN</p>		<p>24. SIGNATURE OF DECEASED</p>		<p>25. SIGNATURE OF NEXT OF KIN</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF NEXT OF KIN</p>		<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF NEXT OF KIN</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF NEXT OF KIN</p>		<p>32. SIGNATURE OF DECEASED</p>		<p>33. SIGNATURE OF NEXT OF KIN</p>		<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF NEXT OF KIN</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF NEXT OF KIN</p>		<p>38. SIGNATURE OF DECEASED</p>		<p>39. SIGNATURE OF NEXT OF KIN</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF NEXT OF KIN</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF NEXT OF KIN</p>		<p>44. SIGNATURE OF DECEASED</p>		<p>45. SIGNATURE OF NEXT OF KIN</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF NEXT OF KIN</p>		<p>48. SIGNATURE OF DECEASED</p>		<p>49. SIGNATURE OF NEXT OF KIN</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF NEXT OF KIN</p>		<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF NEXT OF KIN</p>		<p>54. SIGNATURE OF DECEASED</p>		<p>55. SIGNATURE OF NEXT OF KIN</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF NEXT OF KIN</p>		<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF NEXT OF KIN</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF NEXT OF KIN</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF NEXT OF KIN</p>		<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF NEXT OF KIN</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF NEXT OF KIN</p>		<p>68. SIGNATURE OF DECEASED</p>		<p>69. SIGNATURE OF NEXT OF KIN</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF NEXT OF KIN</p>		<p>72. SIGNATURE OF DECEASED</p>		<p>73. SIGNATURE OF NEXT OF KIN</p>		<p>74. SIGNATURE OF DECEASED</p>		<p>75. SIGNATURE OF NEXT OF KIN</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF NEXT OF KIN</p>		<p>78. SIGNATURE OF DECEASED</p>		<p>79. SIGNATURE OF NEXT OF KIN</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF NEXT OF KIN</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF NEXT OF KIN</p>		<p>84. SIGNATURE OF DECEASED</p>		<p>85. SIGNATURE OF NEXT OF KIN</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF NEXT OF KIN</p>		<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF NEXT OF KIN</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF NEXT OF KIN</p>		<p>92. SIGNATURE OF DECEASED</p>		<p>93. SIGNATURE OF NEXT OF KIN</p>		<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF NEXT OF KIN</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF NEXT OF KIN</p>		<p>98. SIGNATURE OF DECEASED</p>		<p>99. SIGNATURE OF NEXT OF KIN</p>		<p>100. SIGNATURE OF DECEASED</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14229

Reg. Dist. No.

14246

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Rockbridge</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Buena Vista</b> <b>83 X-3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>WILTON</b> Middle <b>E.</b> Last <b>LAWHORNE</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>16</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1939</b>		9. AGE (In years last birthday) <b>20</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Buena Vista, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Grover C. Lawhorne</b>				14. MOTHER'S MAIDEN NAME <b>Elsie Berry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>11/1/56 - 59</b>		17. INFORMANT <b>Capt. Rose, Fort Ritchie, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>825 X</b> DUE TO (b) <b>Fracture Skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>2 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>auto accident on Raven Rock County Road</b>					
20c. TIME OF INJURY Month, Day, Year <b>4:50 a.m. 12-16 1959</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>County Road Smithsburg Washington Md</b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>[Signature]</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. E. W. D. Jr.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>[Signature]</b>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/19/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Buena Vista, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>				ADDRESS <b>Waynesboro, Penna.</b>		24a. REC'D BY REGISTRAR <b>DEC 21 '59</b>	
						24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Jan 15, 1920"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF MEDICAL EXAMINER [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF JURY [Faint signature]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	

## CERTIFICATE OF DEATH

Reg. Dist. No.

14230

14283

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rose Sematha Little</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 21, 1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Funkstown Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Michael Iseminger</b>		14. MOTHER'S MAIDEN NAME <b>Roseann Kerns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>-----</b>	
INFORMANT <b>E. Keller Iseminger</b>		Address <b>Funkstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Stasis ulcer right leg.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 27, 1954</b> to <b>Dec. 26, 1959</b> and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.		21. I certify that I lost saw the deceased alive on <b>Dec. 26, 1959</b>	
ACTUAL SIGNATURE <b>R. A. Bell</b>		DATE SIGNED <b>119 N. Potomac St.</b>	
PHYSICIAN'S NAME (Type) <b>R. A. Bell</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnivh &amp; Son</b>		24a. REC'D BY REGISTRAR <b>DEC 31 '59</b>	
ADDRESS <b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Caribee L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

Washington

County

Washington

Tombstone

Age

Tombstone

33 Tridder Road

22 22

22 22

22 22

22 22

22 22

22

22

22

22

22

22

22

22

Roseanna

Michael

W. Keller

119 E. 10th St.

Washington

W. A. Bell

Rose Hill

11-22-22

Burial

George F. Minnihan & Son



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14231

14247

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON CO. HOSPITAL</b>				d. STREET ADDRESS <b>'30 W. FRANKLIN ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>DANIEL HUGHES LLEWELLYN</b>				4. DATE OF DEATH Month <b>12</b> Day <b>25</b> Year <b>59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 16, 1881</b>		9. AGE (In years last birthday) yrs. <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OFFICE BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID LLEWELLYN</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH WATKINS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>172-07-8817</b>		17. INFORMANT <b>DAVE LLEWELLYN</b> Address <b>HAGERSTOWN, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arterial disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs.</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 25, 189</b> , to <b>Dec 25, 1959</b> , that I last saw the deceased alive on <b>Dec 25, 1959</b> , and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter Layman</b> M.D.				ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg. Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>J. Walter Layman</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/30/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>RICHLAND CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>DRAVOSBURG, PENNA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>FRED W. KRAISS</b> ADDRESS <b>HAGERSTOWN, MD.</b>				24a. REC'D BY REGISTRAR <b>DEC 29 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knecht</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. DECEASED DATE		8. DECEASED TIME		9. DECEASED PLACE	
10. DECEASED CAUSE		11. DECEASED DISEASE		12. DECEASED SYMPTOMS	
13. DECEASED MEDICAL HISTORY		14. DECEASED SURVIVAL		15. DECEASED BURIAL	
16. DECEASED INTERVIEW		17. DECEASED SIGNATURE		18. DECEASED WITNESS	
19. DECEASED OFFICIAL		20. DECEASED COUNTY		21. DECEASED STATE	
22. DECEASED CITY		23. DECEASED ZIP		24. DECEASED COUNTY	
25. DECEASED STATE		26. DECEASED CITY		27. DECEASED ZIP	
28. DECEASED COUNTY		29. DECEASED STATE		30. DECEASED CITY	
31. DECEASED ZIP		32. DECEASED COUNTY		33. DECEASED STATE	
34. DECEASED CITY		35. DECEASED ZIP		36. DECEASED COUNTY	
37. DECEASED STATE		38. DECEASED CITY		39. DECEASED ZIP	
40. DECEASED COUNTY		41. DECEASED STATE		42. DECEASED CITY	
43. DECEASED ZIP		44. DECEASED COUNTY		45. DECEASED STATE	
46. DECEASED CITY		47. DECEASED ZIP		48. DECEASED COUNTY	
49. DECEASED STATE		50. DECEASED CITY		51. DECEASED ZIP	
52. DECEASED COUNTY		53. DECEASED STATE		54. DECEASED CITY	
55. DECEASED ZIP		56. DECEASED COUNTY		57. DECEASED STATE	
58. DECEASED CITY		59. DECEASED ZIP		60. DECEASED COUNTY	
61. DECEASED STATE		62. DECEASED CITY		63. DECEASED ZIP	
64. DECEASED COUNTY		65. DECEASED STATE		66. DECEASED CITY	
67. DECEASED ZIP		68. DECEASED COUNTY		69. DECEASED STATE	
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88. DECEASED COUNTY		89. DECEASED STATE		90. DECEASED CITY	
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94. DECEASED CITY		95. DECEASED ZIP		96. DECEASED COUNTY	
97. DECEASED STATE		98. DECEASED CITY		99. DECEASED ZIP	
100. DECEASED COUNTY		101. DECEASED STATE		102. DECEASED CITY	
103. DECEASED ZIP		104. DECEASED COUNTY		105. DECEASED STATE	
106. DECEASED CITY		107. DECEASED ZIP		108. DECEASED COUNTY	
109. DECEASED STATE		110. DECEASED CITY		111. DECEASED ZIP	
112. DECEASED COUNTY		113. DECEASED STATE		114. DECEASED CITY	
115. DECEASED ZIP		116. DECEASED COUNTY		117. DECEASED STATE	
118. DECEASED CITY		119. DECEASED ZIP		120. DECEASED COUNTY	
121. DECEASED STATE		122. DECEASED CITY		123. DECEASED ZIP	
124. DECEASED COUNTY		125. DECEASED STATE		126. DECEASED CITY	
127. DECEASED ZIP		128. DECEASED COUNTY		129. DECEASED STATE	
130. DECEASED CITY		131. DECEASED ZIP		132. DECEASED COUNTY	
133. DECEASED STATE		134. DECEASED CITY		135. DECEASED ZIP	
136. DECEASED COUNTY		137. DECEASED STATE		138. DECEASED CITY	
139. DECEASED ZIP		140. DECEASED COUNTY		141. DECEASED STATE	
142. DECEASED CITY		143. DECEASED ZIP		144. DECEASED COUNTY	
145. DECEASED STATE		146. DECEASED CITY		147. DECEASED ZIP	
148. DECEASED COUNTY		149. DECEASED STATE		150. DECEASED CITY	
151. DECEASED ZIP		152. DECEASED COUNTY		153. DECEASED STATE	
154. DECEASED CITY		155. DECEASED ZIP		156. DECEASED COUNTY	
157. DECEASED STATE		158. DECEASED CITY		159. DECEASED ZIP	
160. DECEASED COUNTY		161. DECEASED STATE		162. DECEASED CITY	
163. DECEASED ZIP		164. DECEASED COUNTY		165. DECEASED STATE	
166. DECEASED CITY		167. DECEASED ZIP		168. DECEASED COUNTY	
169. DECEASED STATE		170. DECEASED CITY		171. DECEASED ZIP	
172. DECEASED COUNTY		173. DECEASED STATE		174. DECEASED CITY	
175. DECEASED ZIP		176. DECEASED COUNTY		177. DECEASED STATE	
178. DECEASED CITY		179. DECEASED ZIP		180. DECEASED COUNTY	
181. DECEASED STATE		182. DECEASED CITY		183. DECEASED ZIP	
184. DECEASED COUNTY		185. DECEASED STATE		186. DECEASED CITY	
187. DECEASED ZIP		188. DECEASED COUNTY		189. DECEASED STATE	
190. DECEASED CITY		191. DECEASED ZIP		192. DECEASED COUNTY	
193. DECEASED STATE		194. DECEASED CITY		195. DECEASED ZIP	
196. DECEASED COUNTY		197. DECEASED STATE		198. DECEASED CITY	
199. DECEASED ZIP		200. DECEASED COUNTY		201. DECEASED STATE	
202. DECEASED CITY		203. DECEASED ZIP		204. DECEASED COUNTY	
205. DECEASED STATE		206. DECEASED CITY		207. DECEASED ZIP	
208. DECEASED COUNTY		209. DECEASED STATE		210. DECEASED CITY	
211. DECEASED ZIP		212. DECEASED COUNTY		213. DECEASED STATE	
214. DECEASED CITY		215. DECEASED ZIP		216. DECEASED COUNTY	
217. DECEASED STATE		218. DECEASED CITY		219. DECEASED ZIP	
220. DECEASED COUNTY		221. DECEASED STATE		222. DECEASED CITY	
223. DECEASED ZIP		224. DECEASED COUNTY		225. DECEASED STATE	
226. DECEASED CITY		227. DECEASED ZIP		228. DECEASED COUNTY	
229. DECEASED STATE		230. DECEASED CITY		231. DECEASED ZIP	
232. DECEASED COUNTY		233. DECEASED STATE		234. DECEASED CITY	
235. DECEASED ZIP		236. DECEASED COUNTY		237. DECEASED STATE	
238. DECEASED CITY		239. DECEASED ZIP		240. DECEASED COUNTY	
241. DECEASED STATE		242. DECEASED CITY		243. DECEASED ZIP	
244. DECEASED COUNTY		245. DECEASED STATE		246. DECEASED CITY	
247. DECEASED ZIP		248. DECEASED COUNTY		249. DECEASED STATE	
250. DECEASED CITY		251. DECEASED ZIP		252. DECEASED COUNTY	
253. DECEASED STATE		254. DECEASED CITY		255. DECEASED ZIP	
256. DECEASED COUNTY		257. DECEASED STATE		258. DECEASED CITY	
259. DECEASED ZIP		260. DECEASED COUNTY		261. DECEASED STATE	
262. DECEASED CITY		263. DECEASED ZIP		264. DECEASED COUNTY	
265. DECEASED STATE		266. DECEASED CITY		267. DECEASED ZIP	
268. DECEASED COUNTY		269. DECEASED STATE		270. DECEASED CITY	
271. DECEASED ZIP		272. DECEASED COUNTY		273. DECEASED STATE	
274. DECEASED CITY		275. DECEASED ZIP		276. DECEASED COUNTY	
277. DECEASED STATE		278. DECEASED CITY		279. DECEASED ZIP	
280. DECEASED COUNTY		281. DECEASED STATE		282. DECEASED CITY	
283. DECEASED ZIP		284. DECEASED COUNTY		285. DECEASED STATE	
286. DECEASED CITY		287. DECEASED ZIP		288. DECEASED COUNTY	
289. DECEASED STATE		290. DECEASED CITY		291. DECEASED ZIP	
292. DECEASED COUNTY		293. DECEASED STATE		294. DECEASED CITY	
295. DECEASED ZIP		296. DECEASED COUNTY		297. DECEASED STATE	
298. DECEASED CITY		299. DECEASED ZIP		300. DECEASED COUNTY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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14284  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

14232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Frederick</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. 2, Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Year</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Winchester</b>		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Convalescent Home</b>		d. STREET ADDRESS <b>Bloomery Star Route</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>SARAH</b> Last <b>LYNN</b>		4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1875</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>17</b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>George W. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Fahnstock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT <b>Geo. M. Lynn, Sr.</b>		Address <b>537 Frederick St Hagerstown, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>502.1 Acute Cardiac Failure</b> DUE TO (b) <b>Chr. Endocarditis</b> DUE TO (c) <b>Chr. Bronchitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2 yrs.</b> <b>2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 16, 1959</b> to <b>Dec. 13, 1959</b> that I last saw the deceased alive on <b>Dec. 12, 1959</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Brewer</b>		ADDRESS (Street, city or town, state) <b>Clear Spring Md</b>	
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		DATE SIGNED <b>DEC 21 '59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-15-1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Winchester, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b>		24a. REC'D BY REGISTRAR <b>Chas. L. Thomas</b>	
ADDRESS <b>Clear Spring, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. L. Thomas</b>	

CERTIFICATE OF DEATH

1988

STATE OF NEW YORK

County of ...

City of ...

State of New York

On the ... day of ... 1988

I, the undersigned, a duly qualified and licensed ...

do hereby certify that ...

... died on the ... day of ... 1988

at the age of ... years

... of the County of ... State of New York

... Cause of Death ...

... Signed and attested at ...

... on the ... day of ... 1988

... My hand and seal of office ...

... at ...

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

14248

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>MARY</b> Last <b>MANTHEY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 12 1887</b>
9. AGE (In years lost birthday) yrs. <b>72</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland Alleganey Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Augustus Hogan</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lawrence Manthey</b>		Address <b>Cumberland Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Dis.</b> DUE TO (c) <b>2 day</b> INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes; Obesity.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 Mar 1958</b> to <b>2 Dec 1959</b> , that I last saw the deceased alive on <b>2 Dec 1959</b> , and that death occurred at <b>1:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. T. Binford</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>M.D. 1135 POTOMAC AVENUE, HAGERSTON 12/2/59</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M. D.</b>		<b>HAGERSTOWN, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Alleganey Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like 'Name', 'Age', 'Sex', 'Cause of Death' are faintly visible.]*



14285

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood Church Home</b>				d. STREET ADDRESS <b>400 E. Chase Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First		Middle <b>L.</b>		Last <b>MC CLOSKEY</b>	
4. DATE OF DEATH <b>December 17 1959</b>		Month		Day		Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 10, 1873</b>	
9. AGE (In years lost birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frederick Burkhardt</b>				14. MOTHER'S MAIDEN NAME <b>Lovina Bahn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Rev. Mark Wagner</b>				Address <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> DUE TO <b>Anterior inferior MI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral V. &amp; a. collapse</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec 10</b> , 19 <b>59</b> to <b>Dec 18</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Dec 10</b> , 19 <b>59</b> , and that death occurred at <b>8</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 E. Washington St. Hagerstown, Md.</b> DATE SIGNED <b>Arthur S. Kraus</b>							
ACTUAL SIGNATURE <b>Louis G. Graff</b>				PHYSICIAN'S NAME (Type) <b>Louis G. Graff M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12/19/1959</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>				24a. REC'D BY REGISTRAR <b>DEC 21 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 14286 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

14376

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> M		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural 1 Hancock Md</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural 1 Hancock Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Austib</b> Middle <b>William</b> Last <b>McCusker</b>		4. DATE OF DEATH Month <b>12</b> Day <b>31</b> Year <b>19 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3.3.1894</b>		9. AGE (In years last birthday) yrs. <b>65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Fulton County Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John W McCusker</b>		14. MOTHER'S MAIDEN NAME <b>Mary Barnhart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs Anna M McCusker Rural 1 Hancock Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2 Myocarditis</b> DUE TO (b) <b>Pulmonary Emphysema</b> DUE TO (c) <b>Rheumatoid Arthritis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>12/30 19 59</b> to <b>12/31 19 59</b> that I last saw the deceased alive on <b>12/30 19 59</b> and that death occurred at <b>3:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L M Shaffer</b>		ADDRESS (Street, city or town, state) <b>Hancock Md</b>		DATE SIGNED <b>12/30</b>	
PHYSICIAN'S NAME (Type) <b>L M SHAFFER MD</b>		ADDRESS <b>Hancock Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1.2.59</b>		22c. NAME OF CEMETERY OR <del>REMOVAL</del> <b>Mt. Olivet Presbyterian</b>	
22d. LOCATION (City, town, or county) (State) <b>Rural 1 Hancock Washington</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard F. Stone</b>		ADDRESS <b>Hancock Md</b>	
24a. REC'D BY REGISTRAR <b>DATE JAN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Stone</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14235

14249

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>6 Weeks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Morgan</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berkley Springs</u> d. STREET ADDRESS <u>85x-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILLY</u> Middle <u>L</u> Last <u>MESNER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 13 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Romney Hampshire Co W. Va</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas Newell</u>	
14. MOTHER'S MAIDEN NAME <u>Delia Funkhouser</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Owen J? Mesner</u> Address <u>362 Daycotah Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>hypertension - arteriosclerotic heart disease</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Previous acute myocardial infarction 11-13-59</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/15, 1959</u> to <u>12/24, 1959</u> , that I last saw the deceased alive on <u>12/24, 1959</u> , and that death occurred at <u>9:15AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hornbaker</u>		ADDRESS (Street, city or town, state) <u>154 W. Washington St</u> DATE SIGNED <u>12-26-59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. HORNBAKER, M.D.</u>		<u>HAGERSTOWN, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenway Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Berkley Springs Morgan Co W. Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	





14250

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penn</u> b. COUNTY <u>Franklin</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75 x 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Barlock Memorial Home</u>				d. STREET ADDRESS <u>157 Maple Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Allen</u> Last <u>Mummert</u>				4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1874</u>	9. AGE (In years lost birthday) yrs. <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher &amp; Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ministry</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Mummert</u>				14. MOTHER'S MAIDEN NAME <u>Katie Kerfoot</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Lillie M. Mummert, Greencastle, Pa</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>arterio-sclerotic heart dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio</u> DUE TO <u>arterio</u> (c) <u>arterio</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-1-37</u> , 19 <u>37</u> , to <u>12-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-7-30-67</u> , 19 <u>39</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. S. W. D. [Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>12/2/59</u>			
PHYSICIAN'S NAME (Type) <u>Dr. F. W. [Signature]</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Antonia Typ Franklin Co Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman, Greencastle Pa</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>DEC 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02621

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14251

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14257

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>2 Weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>		e. STREET ADDRESS <u>Harmans Alley</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DOROTHY ELIZABETH OBITTS</u>		4. DATE OF DEATH Month Day Year <u>December 17 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 15 1910</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Baker</u>		14. MOTHER'S MAIDEN NAME <u>Lulu Mowen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Beulah Dawson</u>		Address <u>1369 Marshall St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>900.0</u> DUE TO (b) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Fracture Humerus</u>		Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>20 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>21</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>21</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down steps</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11-27 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Washington Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. Dittgen</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Dittgen</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Md</u>		22d. LOCATION (City, town, or county) (State) <u>39 So Greene St Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

1

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DO NOT WRITE IN THESE SPACES

THIS IS A PRELIMINARY REPORT OF THE STATE HEALTH DEPARTMENT. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT TO MAKE THIS REPORT AVAILABLE TO THE PUBLIC. IT IS THE POLICY OF THE DEPARTMENT TO MAKE THIS REPORT AVAILABLE TO THE PUBLIC.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18221

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

14238

14252

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>46 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>817 The Terrace</b>				d. STREET ADDRESS <b>817 The Terrace</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First		Middle <b>CLEMMER</b>		Last <b>PANGBORN</b>	
4. DATE OF DEATH <b>December</b>		Month		Day <b>24</b>		Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 4, 1884</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pangborn Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>LeRoy, Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Pangborn</b>				14. MOTHER'S MAIDEN NAME <b>Anna Morris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-0347</b>		INFORMANT <b>Mrs. Olive Pangborn</b> Address <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Vasc. Disease</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>5 yrs.</b> <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>50</b> , to <b>Dec. 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 24</b> , 19 <b>59</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>214 N. Potomac St.</b> DATE SIGNED <b>12/26/59</b> ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b> M.D. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b> <b>Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/28/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Super-Rouzer Funeral Home</b> <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1922

CERTIFICATE OF DEATH

Washington

Hammond

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Hammond

100 The Terrace

100 The Terrace

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14239

14253

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown-</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hotel Hamilton</b>				d. STREET ADDRESS <b>Hotel Hamilton</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>EARL</b> Last <b>POET</b>				4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 24, 1889</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sheet Metal Worker Aircraft Fac.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. P<sup>O</sup>et</b>				14. MOTHER'S MAIDEN NAME <b>Susan E. Sanders</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>W.W.I</b>		17. INFORMANT <b>R. William Poet</b>		Address <b>Alexandria, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976x</b> DUE TO <b>(b) Gunshot Wound of Head self-inflicted</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(c) instant</b> DUE TO <b>(c)</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <b>11:45 a.m. 12-17-59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hagerstown Washington Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>[Signature]</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>J. E. W. J. T. T. T.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/21/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>R. Rouzer</b>				ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE DEC 23 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14240

Reg. Dist. No.

14287

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. <b>West Virginia</b> b. COUNTY <b>Berkley</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>			c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Martinsburg</b> <span style="float: right;">85X-3</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rt. 40 East 3 miles</b>				d. STREET ADDRESS <b>Route 4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Pickford</b> Middle <b>Price</b> Last <b>Price</b>				<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>4</b> Year <b>1959</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 8, 1933</b>	
<b>9. AGE</b> (In years last birthday) <b>26</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>26</b> Days <b>26</b>		<b>IF UNDER 24 HRS.</b> Hours <b>26</b> Min. <b>26</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Gas &amp; Heating</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Berkley Co. W. Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>			
<b>13. FATHER'S NAME</b> <b>Calvin Price</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Hattie Whitacre</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> Address <b>Calvin Price Rt. 4 Martinsburg W. Va.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull; fractured cervical vertebrae; compound fracture both legs at the knee.</b> DUE TO (b) <b>816X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident - head-on collision with truck.</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>3:55</b> P.M. <b>12/4/59</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>3 mi. east, Rt 40 Hagerstown, Wash., Md.</b>		<b>20f. (City or town)</b> (County) (State)  	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b>  <b>EXAMINER'S NAME (Type)</b> <b>E. W. Ditto, Jr., M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>DATE SIGNED</b> <b>Dec. 4, 1959</b>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>12-7-59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Old Stone Church</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Greenspring W. A.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DEC 7 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



14254

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>18 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 WEST FRANKLIN ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>31 W. FRANKLIN ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NANNIE REID</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER - 25 - 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE - 9 - 1876</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u>16</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SAMPLES MANOR WASH. Co. MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN MOORE</u>				14. MOTHER'S MAIDEN NAME <u>MARY CATHERINE MORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS. VERNON H. SHOWIE</u>				Address <u>31 WEST FRANKLIN ST. HAGERSTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>General arteriosclerosis</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>+ cerebral thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 12, 1958</u> , to <u>Dec 25, 1959</u> , that I last saw the deceased alive on <u>Dec 23, 1959</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 West Washington St. Dec. 26, 59</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M. D. Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec. 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SHARPSBURG WASH. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u> ADDRESS <u>BOONSBORO MD.</u>				24. REC'D BY REGISTRAR <u>DEC 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll S. Kneass</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

DECEASED

MALE

1924

1. Name of deceased  
2. Sex  
3. Age  
4. Date of death  
5. Place of death  
6. Cause of death  
7. Signature of physician  
8. Signature of registrar  
9. Date of registration



14255

## CERTIFICATE OF DEATH

14242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>18 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>920 LANVALE ST.,</b>		d. STREET ADDRESS <b>1 920 LANVALE ST.,</b>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SARAH REBECCA ROBINETTE</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 2 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 4, 1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME DUTIES</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE WORK</b>	
11. BIRTHPLACE (State or foreign country) <b>OLDTOWN, MD,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA ARNOLD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ALBERT HARRIS</b>		Address <b>920 LANVALE ST.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Endocarditis</b> 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 1, 1957</b> to <b>Dec. 2, 1959</b> , that I last saw the deceased alive on <b>Dec. 1, 1959</b> , and that death occurred at <b>6:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David R. Brewer</b>		DATE SIGNED <b>12/3/59</b>	
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>		ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>DEC. 5, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Clark</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>	
ADDRESS <b>CLEAR SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WATKINS STATE DEPARTMENT OF HEALTH - BATHING

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14256

## CERTIFICATE OF DEATH

Reg. Dist. No.

14243

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Conv. Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>VIRGINIA</u> Last <u>ROESSNER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Downsville Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Gordon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John W Roessner</u>		Address <u>511 Gordon Circle</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Generalized &amp; cerebral arteriosclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days -</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/27, 1942</u> to <u>12-7, 1959</u> , that I last saw the deceased alive on <u>12/6, 1959</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H Hornbaker</u>		ADDRESS (Street, city or town, state) <u>154 West Washington Street</u>	
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1921



1

14257

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 hr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>230 N. Potomac Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES CASSIOUS RUTHERFORD</b>				4. DATE OF DEATH Month Day Year <b>December 5 19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 24, 1893</b>		9. AGE (In years lost birthday) yrs. <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Private home</b>		11. BIRTHPLACE (State or foreign country) <b>Charlestown, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John William Rutherford</b>				14. MOTHER'S MAIDEN NAME <b>Naomi Fields</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. I 236-28-5733</b>		INFORMANT <b>Malinda R. Love</b>		Address <b>Charles town, W. Virginia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic heart disease with acute</b> <b>420.0</b> DUE TO <b>rt. sided Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1946</b> to <b>5 Dec 1959</b> , that I last saw the deceased alive on <b>3 Dec 1959</b> , and that death occurred at <b>9:41 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>FF Lusby</b>				ADDRESS (Street, city or town, state) <b>230 N Potomac St Hagerstown</b>			
PHYSICIAN'S NAME (Type) <b>FF Lusby</b>				DATE SIGNED <b>8 Dec 59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/9/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Charlestown, W. Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Super-Rouzer Funeral Home</b> <b>R. Franklin Rouzer</b>				ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

300

Washington

Virginia

Washington

Washington

Washington

100 West North Street

100 West North Street

WASHINGTON

WASHINGTON

WASHINGTON

October 20, 1957

October 20, 1957

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C. 20001

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14245

Reg. Dist. No.

14258

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 6 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>931 C. Lanvale St.</b>				d. STREET ADDRESS <b>931 C. Lanvale St.</b>		e. IS RESIDENCE "ON A FARM?" YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Sapia</b> Last <b>Sapia</b>				4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 18, 1938</b>	
9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>metal stairways Baltimore, Md.</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ralph Sapia, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Leary</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>219-34-5550</b>		17. INFORMANT Address <b>Florence M. Sapia, Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976x</b> DUE TO <b>(b) Gun shot wound of head</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(c) Self inflicted</b></p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>instant</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted gun shot wound of head</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>10</b> o. m. <b>12-27</b> 19 <b>59</b> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY OR TOWN (County) (State) <b>Hagerstown Washington Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>A. S. Smith</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>DREW H. T. T. 9</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12-30-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Garden</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Kline</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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15-30-28

14246

14259

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>837 Maryland Ave</b>			
3. NAME OF DECEASED (Type or print) <b>DEWEY ADMIRAL SARGENT</b>				4. DATE OF DEATH Month <b>DEC.</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 28, 1898</b>	
9. AGE (In years lost birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>20</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Sargent</b>				14. MOTHER'S MAIDEN NAME <b>Emma Turner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>227-09-5361</b>		INFORMANT Address <b>Mrs. Nora Sargent, Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF LUNGS &amp; SPINE</b> <b>180X</b> DUE TO (b) <b>CARCINOMA OF LEFT KIDNEY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) <b>2 YEARS</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 9, 1959</b> to <b>DEC. 18, 1959</b> , that I last saw the deceased alive on <b>DEC. 18, 1959</b> , and that death occurred at <b>10:35 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>George Beren</b> <b>1500 PENNSYLVANIA AVE. 12/18/59</b> M.D. <b>HAGERSTOWN, MARYLAND</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>DR. GEORGE BERCU</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-21-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Winchester, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

**TO HOSPITAL QUALITY ASSURANCE:** The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

12553

CERTIFICATE OF DEATH

Marriage

Marriage

Marriage

DEWEY ADMIRAL SARGENT

DEWEY ADMIRAL SARGENT

DEWEY ADMIRAL SARGENT

DEWEY ADMIRAL SARGENT

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DEWEY ADMIRAL SARGENT

DEWEY ADMIRAL SARGENT

## CERTIFICATE OF DEATH

Reg. Dist. No.

14288

14247

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BREATHEDSVILLE - RURAL</u>				c. LENGTH OF STAY IN 1b <u>75 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R.I.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARVEY R SCUFFINS</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER - 28. 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DECEMBER 18, 1878</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>ROHRERSVILLE WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES SCUFFINS</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN BOYER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT <u>MRS. GERTRUDE SCUFFINS</u> Address <u>BOONSBORO MD. R.I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis -</u> DUE TO (c) <u>57 year -</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>March</u> , 19 <u>59</u> , to <u>December</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 20, 1959</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stefen...</u>				ADDRESS (Street, city or town, state) <u>21 North Main Street</u>		DATE SIGNED <u>12/29</u>	
PHYSICIAN'S NAME (Type) <u>Joseph Secondari</u>				<u>Boonsboro, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 31, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Bass</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>IAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11911

CERTIFICATE OF DEATH

11911

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DECEASED

DATE OF DEATH



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14248

14260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. Co. Hospital				d. STREET ADDRESS 124 John St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary E Shoemaker				4. DATE OF DEATH Month Day Year 12 11 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-14-1887	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Clearspring, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Adam Repp				14. MOTHER'S MAIDEN NAME Rose Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-30-9982		17. INFORMANT Sylvester Shoemaker		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease 6 Years (c) Fractured Humerus + Femur 24 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Washington Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE J. E. W. J. T. Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) J. E. W. J. T. Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Hagerstown Md. 12/14/59			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-15-59		22c. NAME OF CEMETERY OR CREMATORY St. Pauls		22d. LOCATION (City, town, or county) (State) Hagerstown rural Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.			
24a. REC'D BY REGISTRAR DATE DEC 15 '59				24b. REGISTRAR'S SIGNATURE Charles S. Hume			



14261

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>6 days</u>		x c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R. D. #1 Smithsburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Alton</u> Middle <u>Glenn</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>19 59</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6, 1904</u>		
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Work</u>		11. BIRTHPLACE (State or foreign country) <u>Smithsburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos M. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Clara I. Lewis</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		INFORMANT <u>Mrs. Bertha Warner, R.D.#2 Smithsburg Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMOPNEUMONIA</u> <u>286.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>SEVERE MALNUTRITION</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>DEC. 24</u> , 19 <u>59</u> , to <u>DEC. 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>DEC. 30</u> , 19 <u>59</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>12 South Main St Smithsburg Md.</u> DATE SIGNED <u>12-31-59</u>								
ACTUAL SIGNATURE <u>E. R. Laddizabal</u>		PHYSICIAN'S NAME (Type) <u>E. R. Laddizabal</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 2, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wolfville Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son Smithsburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1931

1931

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

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PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

## Reg. Dist. No.

14262

MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/SB

CERTIFICATE OF DEATH

1923

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1923

NAME OF DECEASED: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

RACE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

Cause of Death: \_\_\_\_\_

Signature of Registrar: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_



## CERTIFICATE OF DEATH

Reg. Dist. No. 302

14251

14263

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>rear 276 So Potomac St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VIOLA</b> Middle <b>MAY</b> Last <b>SNYDER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3 1900</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Luther Davis</b>		14. MOTHER'S MAIDEN NAME <b>Minnie May Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-7918</b>	
17. INFORMANT <b>Lewis F. Snyder</b>		Address <b>276 So Potomac St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/23/59</b> to <b>12/23/59</b> , that I last saw the deceased alive on <b>12/23/59</b> , 19 <b>59</b> , and that death occurred at <b>12/23/59</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Leigh E. Young</b> M.D. <b>William H. Hager</b> <b>12/24/59</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 28 59</b>		DATE <b>DEC 28 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hager</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1883

M

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14252

14289

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Hancock Wash Co</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Allegany</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> <b>01-22-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hancock Rest Home</b>				d. STREET ADDRESS <b>573 Arnett Terrace</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>ELIZABETH</b> Last <b>STEIN</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>22</b> Year <b>1959</b>			
5. SEX <b>Fem</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 10, 1884</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jesse F. Young</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Long</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>zNone</b>		17. INFORMANT <b>Mr. George T. Stein 573 Arnett Terrace,</b> Address <b>Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STROKE</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>11 HRS.</b> <b>20 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture Left hip</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home</b>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Oct</b> 1959 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		
			20f. (City or town) <b>Cumberland</b>		20g. (County) (State) <b>Allegany Md.</b>		
21. I certify that I attended the deceased from <b>Dec. 22, 1959</b> , to _____, 19____, that I last saw the deceased alive on <b>Dec. 22, 1959</b> , and that death occurred at <b>10:45 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 High Street</b> DATE SIGNED <b>Dec. 23, 1959</b>							
ACTUAL SIGNATURE <b>Frank B. Thomas III, M.D.</b> M.D. <b>121 High Street</b> <b>Dec. 23, 1959</b>							
PHYSICIAN'S NAME (Type) <b>Frank B. Thomas III, MD, Hancock, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1988

DECEASED  
TAMM, ERIC  
MAY 19 1988

NAME OF DECEASED		TAMM, ERIC	
DATE OF DEATH		MAY 19 1988	
PLACE OF DEATH		HOSPITAL	
AGE		21	
SEX		M	
RACE		W	
EDUCATION		HIGH SCHOOL	
OCCUPATION		STUDENT	
MARRIAGE		SINGLE	
RELIGION		CATHOLIC	
CAUSE OF DEATH		SUICIDE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	
DATE OF REGISTRATION		MAY 20 1988	
PLACE OF REGISTRATION		BALTIMORE, MD	
OFFICIAL USE		[Stamp]	

1  
Page 4  
death. Pages 1 and 2 should be filed with the funeral director.  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14253

14264

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>SMITH</b> Last <b>STEWART JR.</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/5/59</b>
9. AGE (In years last birthday) <b>25</b>		10. IF UNDER 1 YEAR Months <b>25</b> Days <b>05</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT S. STEWART SR.</b>		14. MOTHER'S MAIDEN NAME <b>ROSEALIE HEAD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. ROBERT S. STEWART SR.</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5</b> <b>CONGENITAL HEART DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>25 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 5</b> , 19 <b>59</b> , to <b>Dec 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 29</b> , 19 <b>59</b> , and that death occurred at <b>4:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W. Washington St. Hagerstown Md.</b> DATE SIGNED <b>12/31/59</b> ACTUAL SIGNATURE <b>[Signature]</b> PHYSICIAN'S NAME (Type) <b>[Signature]</b>			
22a. BURIAL, CREMATION, ETC. (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

2081191XV3

1923

CERTIFICATE OF DEATH

1923

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14290

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA - RURAL</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BOONSBORO MD. R. 2</u>		e. STREET ADDRESS <u>BOONSBORO MD. R. 2</u>	
3. NAME OF DECEASED (Type or print) <u>WOODROW WILSON STOTTLEMYER</u>		4. DATE OF DEATH <u>DECEMBER 25, 1959</u>	
5. SEX <u>MALIE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB - 4 - 1914</u>
9. AGE (In years last birthday) <u>45 yrs.</u>		10. IF UNDER 1 YEAR <u>10</u> Months <u>21</u> Days <u>1</u> Hours <u>1</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHEET METAL WORKER</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>FAIRCHILD AIRCRAFT</u>	
12. BIRTHPLACE (State or foreign country) <u>MT. LENA WASH. CO. MD. U.S.A.</u>		13. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
14. FATHER'S NAME <u>CHARLES IRVING STOTTLEMYER</u>		15. MOTHER'S MAIDEN NAME <u>ANNIE HOUST</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		17. SOCIAL SECURITY NO. <u>214-09-2336</u>	
18. INFORMANT <u>MRS. MILDRED STOTTLEMYER</u>		Address <u>BOONSBORO MD. R. 2</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976X</u> DUE TO <u>Gun shot wound of head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Self inflicted</u> DUE TO (c) <u>Self inflicted</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>shot self with 30-30 rifle thru chin</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot self with 30-30 rifle thru chin</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-25-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Boonsboro Wash. Md</u> (County) <u>Washington</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DR. E. W. TITTO</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-26-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		22d. LOCATION (City, town, or county) <u>MT. LENA WASH. CO. MD.</u> (State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bast</u>		24. REC'D BY REGISTRAR <u>DEC 31 '59</u>	
ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

M

DR. DITTO

I

2

AP

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: \_\_\_\_\_

4. RACE: \_\_\_\_\_

5. OCCUPATION: \_\_\_\_\_

6. PLACE OF BIRTH: \_\_\_\_\_

7. DATE OF BIRTH: \_\_\_\_\_

8. DATE OF DEATH: \_\_\_\_\_

9. TIME OF DEATH: \_\_\_\_\_

10. PLACE OF DEATH: \_\_\_\_\_

11. CAUSE OF DEATH: \_\_\_\_\_

12. MANNER OF DEATH: \_\_\_\_\_

13. SIGNATURE OF MEDICAL EXAMINER: \_\_\_\_\_

14. SIGNATURE OF CORONER: \_\_\_\_\_

15. SIGNATURE OF JURY: \_\_\_\_\_

16. SIGNATURE OF WITNESSES: \_\_\_\_\_

17. SIGNATURE OF DECEASED: \_\_\_\_\_

18. SIGNATURE OF NEXT OF KIN: \_\_\_\_\_

19. SIGNATURE OF CLERGYMAN: \_\_\_\_\_

20. SIGNATURE OF MINISTER: \_\_\_\_\_

21. SIGNATURE OF CHURCH: \_\_\_\_\_

22. SIGNATURE OF FUNERAL HOME: \_\_\_\_\_

23. SIGNATURE OF BURIAL PLACE: \_\_\_\_\_

24. SIGNATURE OF CEMETERY: \_\_\_\_\_

25. SIGNATURE OF INTERMENT: \_\_\_\_\_

26. SIGNATURE OF CREMATION: \_\_\_\_\_

27. SIGNATURE OF OTHER: \_\_\_\_\_

28. SIGNATURE OF OTHER: \_\_\_\_\_

29. SIGNATURE OF OTHER: \_\_\_\_\_

30. SIGNATURE OF OTHER: \_\_\_\_\_

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99. SIGNATURE OF OTHER: \_\_\_\_\_

100. SIGNATURE OF OTHER: \_\_\_\_\_

14265

## CERTIFICATE OF DEATH

Reg. Dist. No.

14255  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>34 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>800 Washington Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>EDGAR</b> Last <b>STOUT</b>				4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 26, 1905</b>	
9. AGE (In years last birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>14</b> Hours <b>19</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Greencastle, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Greencastle, Pennsylvania</b>	
13. FATHER'S NAME <b>Lewis Stout</b>				14. MOTHER'S MAIDEN NAME <b>Liza Wolfe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-10-5658</b>		INFORMANT <b>Mrs. Grace Stout</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3yrs. 9mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work _____ Not while <input type="checkbox"/> at work _____		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Nov. 22</b> , 19 <b>59</b> , to <b>Dec. 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 13</b> , 19 <b>59</b> , and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above. EST ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <i>W. T. Layman, MD</i>				M.D. <b>100 Professional Arts Bldg. 12/15/59</b>			
PHYSICIAN'S NAME (Type) <b>William T. Layman</b>				<b>Hagerstown Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/16/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Suter-Rouzer</i> <b>Suter-Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 17 '59</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12268

CERTIFICATE OF DEATH

Washington

Washington

John Brown

31 years

Washington

100 Washington Ave.

100 Washington Ave.

WILLIAM

WILLIAM

Washington

John Brown

John Brown

John Brown

Washington, D.C.

John Brown

John Brown

1901-1902

John Brown

Washington, D.C.

John Brown

John Brown

Dec. 12

Nov. 22

Dec. 14

William T. Brown

Washington

Washington

John Brown

John Brown

John Brown

Washington

Washington

Washington, D.C.

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

14291  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

14256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROUTE 2, CLEAR SPRING, MD.</b>		c. LENGTH OF STAY IN 1b <b>16 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROUTE 2, CLEAR SPRING, MD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AGUSTON STRUCKMAN</b>		4. DATE OF DEATH <b>DECEMBER 28, 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 27, 1876</b>
9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR <b>5</b> Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
11. BIRTHPLACE (State or foreign country) <b>FLINTSTONE MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FREDERICK STRUCKMAN</b>		14. MOTHER'S MAIDEN NAME <b>MELINDA HARTSOCK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-10-7930</b>	
17. INFORMANT <b>WARD STRUCKMAN, ROUTE 2, CLSPG.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Dis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 2, 1959</b> to <b>Dec 28, 1959</b> , that I last saw the deceased alive on <b>Dec 28, 1959</b> , and that death occurred at <b>49</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>David R. Brewer</b> ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b> DATE SIGNED <b>12/28/59</b> PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC. 30, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN MEMORIAL GARDENS, CEDAR LAWN, MD.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Clark</b> ADDRESS <b>Clear Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 31 '59</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>C. L. S. Hines</b>			

CERTIFICATE OF DEATH

1921

WILL BOND

George

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. BOND		M		45		JAN 15 1876		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
Carpenter		Heart Disease		Natural		BALTIMORE, MD		JAN 15 1921	
EDUCATION		RELIGION		RACE		COLOR		MARITAL STATUS	
High School		Roman Catholic		White		White		Married	
PREVIOUS ILLNESS		TREATMENT		HISTORY		SYMPTOMS		DIAGNOSIS	
None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF REGISTRAR	
J. H. Bond		J. H. Bond		J. H. Bond		J. H. Bond		J. H. Bond	



## CERTIFICATE OF DEATH

Reg. Dist. No.

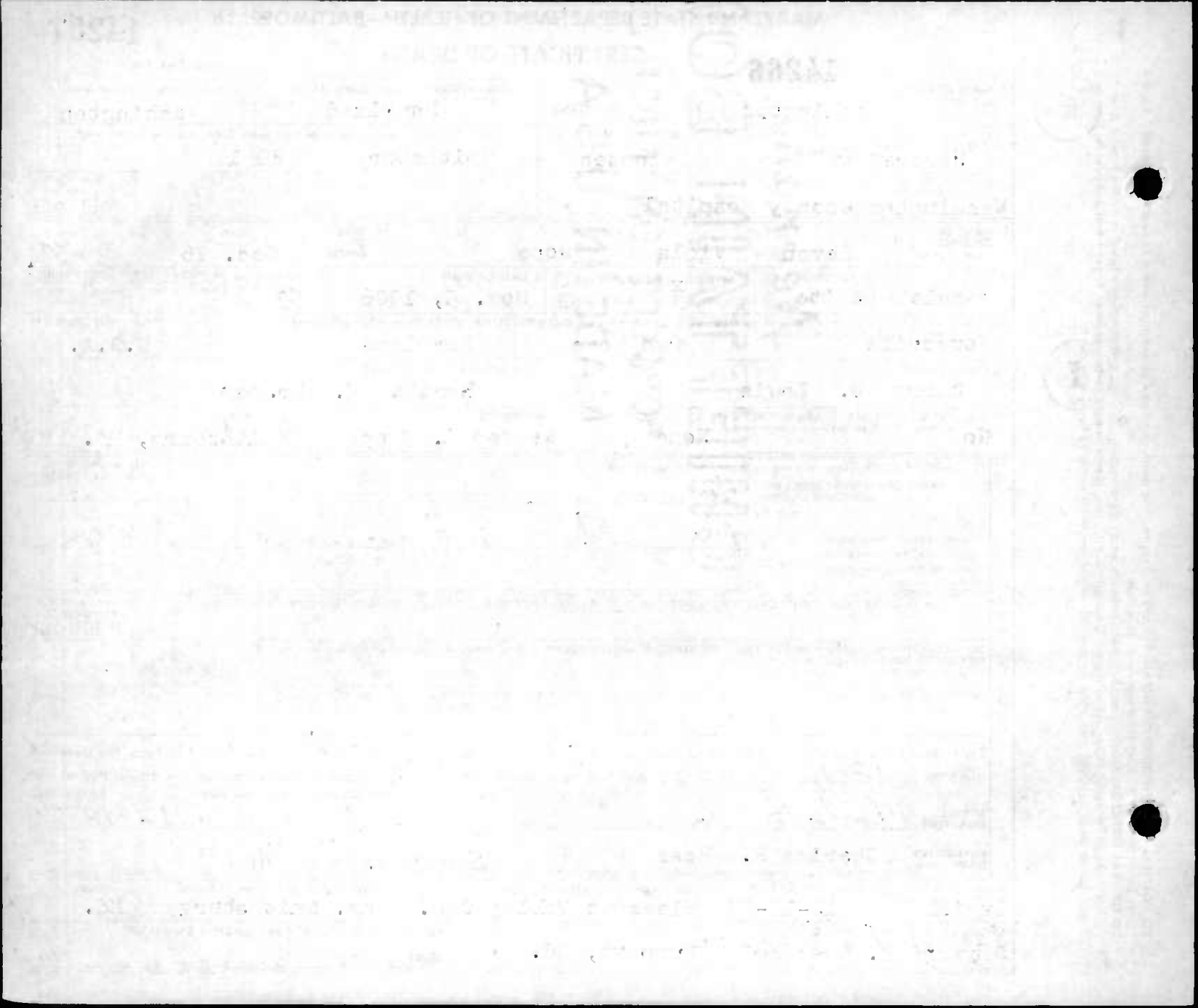
14266

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Haven Middle Viola Last Swope		4. DATE OF DEATH Month Dec. 16 Day Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1906
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry W. Lewis		14. MOTHER'S MAIDEN NAME Martha E. Draper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Keefer L. Swope		Address Smithsburg, Md. Rpt	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Rheumatic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10 yrs.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1, 1959, to 12-16, 1959, that I last saw the deceased alive on 12-10, 1959, and that death occurred at 10:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12-16-59 ACTUAL SIGNATURE Charles F. Hess M.D. PHYSICIAN'S NAME (Type) Charles F. Hess Smithsburg Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-59	
22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cem.		22d. LOCATION (City, town, or county) (State) nr. Smithsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		24a. REC'D BY REGISTRAR DEC 21 '59	
ADDRESS Thurmont, Md.		24b. REGISTRAR'S SIGNATURE Charles L. Hess	

1

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58





1883

CERTIFICATE OF DEATH

Washington

Hayes Town

5 days

Washington County, Maryland

WITHIN THE PARISH OF ST. JOHN, PARISH OF ST. JOHN, PARISH OF ST. JOHN

Female, White, born in Maryland, December 17, 1883

Donna Marie

Donna Marie, born in Maryland, December 17, 1883

Donna Marie

Donna Marie

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Donna Marie, born in Maryland, December 17, 1883

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Donna Marie, born in Maryland, December 17, 1883

Donna Marie, born in Maryland, December 17, 1883

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)  
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 14259									
Item 18 Film 254 1-5-60 ans									
14268									
1. PLACE OF DEATH a. COUNTY <u>DIST WASHINGTON CTY. Hosp. MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES B. THOMAS</u>					4. DATE OF DEATH Month Day Year <u>Dec. 22, 1959</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.E.P.CO</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>WM H. THOMAS</u>					14. MOTHER'S MAIDEN NAME <u>MARY A. McDONALD</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>					16. SOCIAL SECURITY NO. <u>WORLDWIDE (577-09-3311)</u>				
17. INFORMANT <u>William H. BROTHIER</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> <u>322.0</u> DUE TO <u>Fatty Change Liver, Marked</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Alcoholic Intoxication</u> DUE TO <u>Acute Alcoholism</u> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>									
22b. DATE THEREOF <u>Dec 26, 1959</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>									
22d. LOCATION (City, town, or county) (State) <u>SUITLAND MD</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Taltrow</u> ADDRESS <u>3603 14th St NW Wash. DC</u>									
24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-20-63

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF JAILER		23. SIGNATURE OF WARDEN		24. SIGNATURE OF CHIEF OF POLICE	
25. SIGNATURE OF DETECTIVE		26. SIGNATURE OF INSPECTOR		27. SIGNATURE OF SUPERVISOR	
28. SIGNATURE OF AGENT		29. SIGNATURE OF CLERK		30. SIGNATURE OF RECEPTIONIST	
31. SIGNATURE OF MAIL ROOM		32. SIGNATURE OF TELEPHONE ROOM		33. SIGNATURE OF JANITOR	
34. SIGNATURE OF GARDENER		35. SIGNATURE OF PEON		36. SIGNATURE OF PORTER	
37. SIGNATURE OF COOK		38. SIGNATURE OF BUTLER		39. SIGNATURE OF HOUSEKEEPER	
40. SIGNATURE OF MAINTENANCE		41. SIGNATURE OF SECURITY		42. SIGNATURE OF RECORDS	
43. SIGNATURE OF TRAINING		44. SIGNATURE OF RESEARCH		45. SIGNATURE OF EVALUATION	
46. SIGNATURE OF PLANNING		47. SIGNATURE OF IMPLEMENTATION		48. SIGNATURE OF MONITORING	
49. SIGNATURE OF IMPROVEMENT		50. SIGNATURE OF CLOSURE		51. SIGNATURE OF REVISION	
52. SIGNATURE OF DELETION		53. SIGNATURE OF ARCHIVING		54. SIGNATURE OF RETENTION	
55. SIGNATURE OF DISPOSITION		56. SIGNATURE OF RECORDS		57. SIGNATURE OF INFORMATION	
58. SIGNATURE OF COMMUNICATION		59. SIGNATURE OF RELATIONSHIP		60. SIGNATURE OF INTERACTION	
61. SIGNATURE OF INFLUENCE		62. SIGNATURE OF COOPERATION		63. SIGNATURE OF PARTICIPATION	
64. SIGNATURE OF CONTRIBUTION		65. SIGNATURE OF COMMITMENT		66. SIGNATURE OF RESPONSIBILITY	
67. SIGNATURE OF ACCOUNTABILITY		68. SIGNATURE OF TRANSPARENCY		69. SIGNATURE OF INTEGRITY	
70. SIGNATURE OF ETHICS		71. SIGNATURE OF PROFESSIONALISM		72. SIGNATURE OF EXCELLENCE	
73. SIGNATURE OF INNOVATION		74. SIGNATURE OF CREATIVITY		75. SIGNATURE OF IMAGINATION	
76. SIGNATURE OF VISION		77. SIGNATURE OF LEADERSHIP		78. SIGNATURE OF TEAMWORK	
79. SIGNATURE OF COLLABORATION		80. SIGNATURE OF PARTNERSHIP		81. SIGNATURE OF ALLIANCE	
82. SIGNATURE OF COOPERATION		83. SIGNATURE OF SUPPORT		84. SIGNATURE OF ASSISTANCE	
85. SIGNATURE OF HELP		86. SIGNATURE OF GUIDANCE		87. SIGNATURE OF COUNSEL	
88. SIGNATURE OF ADVICE		89. SIGNATURE OF WARNING		90. SIGNATURE OF CAUTION	
91. SIGNATURE OF ALERTNESS		92. SIGNATURE OF AWARENESS		93. SIGNATURE OF CONSCIOUSNESS	
94. SIGNATURE OF ATTENTION		95. SIGNATURE OF INTEREST		96. SIGNATURE OF CONCERN	
97. SIGNATURE OF CARE		98. SIGNATURE OF DEDICATION		99. SIGNATURE OF COMMITMENT	
100. SIGNATURE OF PASSION		101. SIGNATURE OF ENTHUSIASM		102. SIGNATURE OF ENERGY	
103. SIGNATURE OF MOTIVATION		104. SIGNATURE OF DRIVE		105. SIGNATURE OF DETERMINATION	
106. SIGNATURE OF RESOLUTION		107. SIGNATURE OF COURAGE		108. SIGNATURE OF BRAVERY	
109. SIGNATURE OF VALIANTNESS		110. SIGNATURE OF HEROISM		111. SIGNATURE OF GALLANTRY	
112. SIGNATURE OF VALOR		113. SIGNATURE OF COURAGE		114. SIGNATURE OF BRAVERY	
115. SIGNATURE OF VALIANTNESS		116. SIGNATURE OF HEROISM		117. SIGNATURE OF GALLANTRY	
118. SIGNATURE OF VALOR		119. SIGNATURE OF COURAGE		120. SIGNATURE OF BRAVERY	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14260

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Hook</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Hook</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>ELIZABETH</b> Last <b>THOMPSON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 5, 1906</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Garrett's Mill, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry E. Nokes</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Pearl Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Claude R. Thompson, Box 152 R.F.D.#1, Knoxville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic nephritis</b> <b>592x</b> DUE TO <b>acute congestive failure</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/18</b> , 19 <b>59</b> , to <b>12/19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/18</b> , 19 <b>59</b> , and that death occurred at <b>7 a.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Md</b> DATE SIGNED <b>12/19/59</b> ACTUAL SIGNATURE <b>W. B. Carpenter</b> M.D. <b>W. B. Carpenter</b> PHYSICIAN'S NAME (Type) <b>W. B. Carpenter, M.D.</b> <b>Brunswick, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Brethren Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brownsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald Cackles</b>		24a. REC'D BY REGISTRAR <b>DEC 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



14293

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 3 Sharpsburg</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>FREDERICK</b> Last <b>THURSTON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 3, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contract Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Calvin B. Thurston</b>		14. MOTHER'S MAIDEN NAME <b>Lucretia Ann Schleigh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Informant</b> <b>Mrs. Cora T. Hockersmith Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis primary in Prostate</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>177X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>20 mon.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 13, 1958</b> , to <b>Dec. 19, 1959</b> , that I last saw the deceased alive on <b>Dec. 18, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St. 12-20-59</b> DATE SIGNED ACTUAL SIGNATURE <b>R.A. Bell</b> M.D. PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b> <b>Hagerstown, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>12/20/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Calvin B. Newton

THE UNIVERSITY OF CHICAGO

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22. *Problemas*

Robert-Boyer-Kennel, Hove

14294

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Waynesboro</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lois</u> <u>Todd</u>		4. DATE OF DEATH Month Day Year <u>December 18, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>The Grove, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William E. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Bladas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
INFORMANT <u>Miss Isabel Todd, 503 S. Potomac St.</u>		Address <u>Waynesboro, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cardio-Respiratory Arrest</u> DUE TO (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>24 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous repeated "strokes"</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1, 1959</u> to <u>Dec 18, 1959</u> that I last saw the deceased alive on <u>December 18, 1959</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Byrkit</u> M.D.		ADDRESS (Street, city or town, state) <u>28 W Potomac</u> DATE SIGNED <u>12-18-59</u>	
PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>		<u>Williamsport Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Marlin Poe</u>		ADDRESS <u>Waynesboro, Penna.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3. 4. 1991

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14263

14269

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>321 NOTTINGHAM RD.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>VIRGINIA</b> Last <b>TROVINGER</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/1915</b>
9. AGE (In years lost birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT L. COLVIN</b>		14. MOTHER'S MAIDEN NAME <b>LEVINA HUTCHINSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. LLOYD C. TROVINGER</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic melanoma of the liver</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 17</b> , 19 <b>59</b> to <b>Dec. 2</b> , 19 <b>59</b> and that death occurred at <b>3:15</b> P.M. from the causes and on the date stated above. olive on <b>Dec. 2</b> , 19 <b>59</b> , and that death occurred at <b>3:15</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington St. Hagerstown, Maryland</b> DATE SIGNED <b>12/4/59</b>			
ACTUAL SIGNATURE <b>B. B. Kneisley</b>		M.D. <b>148 West Washington St. Hagerstown, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/5/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneisley</b>	

B.P.

14503

CENTRAL CASE OF DEATH

14503

M

MILITARY

1

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14264

14270

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1825 Sheridan Ave</b>		d. STREET ADDRESS <b>1825 Sheridan Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Frederick Thomas White Jr.</b>		4. DATE OF DEATH <b>December 21 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1915</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>bartender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cafe</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frederick T. White Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Guessford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W. W. 11 214-09-5222</b>	
17. INFORMANT <b>William H. White</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Recent</b> (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward W. Ditto Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edward W. Ditto Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-23-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		24a. REC'D BY REGISTRAR <b>DEC 23 '59</b>	
<b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Hagerstown  
Washington

2 years

Hagerstown

1825 Sheridan Ave.

1825 Sheridan Ave.

Frederick

Thomas

White Jr.

December 31

Male

White

Nov. 9, 1915

AA

Washington

care

Hagerstown Md.

U. S. A.

Frederick T. White Sr.

any Gussard

W. W. II

111-09-5232 William H. White Hagerstown Md.

Burial 12-23-22

West Haven Cemetery

Hagerstown Md.

Scott F. Minnich & Son Hagerstown Md.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14295

## CERTIFICATE OF DEATH

Reg. Dist. No.

14265

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>				c. LENGTH OF STAY IN 1b <b>50 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Widmyer</b>				4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 8. 1867</b>	
9. AGE (In years last birthday) yrs. <b>92</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Morgan County W.VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry McBee</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Higgons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Roy Hoyle 140 Land Wehr Lane Baltimore Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>30 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1</b> , 19 <b>59</b> , to <b>Dec. 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 5</b> , 19 <b>59</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>121 High Street</b> DATE SIGNED <b>Dec. 8, 1959</b>							
ACTUAL SIGNATURE <b>Frank B Thomas III MD</b> M.D.				DATE SIGNED <b>Dec. 8, 1959</b>			
PHYSICIAN'S NAME (Type) <b>Frank B. Thomas III M.D.</b>				<b>Hancock, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12.9.59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spohrs Cross Roads</b>		22d. LOCATION (City, town, or county) (State) <b>Morgan County W.VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Stone</b>				ADDRESS <b>Hancock, Md</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 11 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14266

14271

Item 8 Filed 12-28-59

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>301-4</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Enroute by Greyhound Bus</b>				d. STREET ADDRESS <b>851 Glade Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>L.</b> Last <b>Wolgast</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>12</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1913</b>		9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months <b>46</b> Days <b>46</b>	IF UNDER 24 HRS. Hours <b>46</b> Min. <b>46</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b> <b>??</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>101640-1257</b>		17. INFORMANT Address <b>Andrew C. Currie, Box 81, New Stanton, Penna.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>MYOCARDIAL INFARCTION</b> (c) <b>RESENT</b> DUE TO (a) stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>E. W. DITTO, JR.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>DR. E.W. DITTO, JR.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/16/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b> <b>5501 Frederick Ave., Baltimore.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Martin Poe</b>				ADDRESS <b>Waynesboro, Penna.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. J. ...</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <b>JOHN J. LITTLE, JR.</b>		AGE <b>35</b>		SEX <b>Male</b>		RACE <b>White</b>		DATE OF BIRTH <b>1910</b>		PLACE OF BIRTH <b>Baltimore, Md.</b>	
MARRIAGE <b>Married</b>		EDUCATION <b>High School</b>		OCCUPATION <b>Engineer</b>		RELIGION <b>Catholic</b>		MILITARY SERVICE <b>None</b>		DATE OF DEATH <b>Dec. 13, 1952</b>	
CAUSE OF DEATH <b>Myocardial Infarction</b>		MANNER OF DEATH <b>Natural</b>		PLACE OF DEATH <b>Home</b>		DATE OF DEATH <b>Dec. 13, 1952</b>		TIME OF DEATH <b>10:15 AM</b>		SIGNATURE OF EXAMINER <b>DR. E. J. LITTLE, JR.</b>	
SIGNATURE OF DECEASED <b>John J. Little, Jr.</b>		SIGNATURE OF NEXT OF KIN <b>John J. Little, Sr.</b>		SIGNATURE OF WITNESS <b>John J. Little, Sr.</b>		SIGNATURE OF WITNESS <b>John J. Little, Sr.</b>		SIGNATURE OF WITNESS <b>John J. Little, Sr.</b>		SIGNATURE OF WITNESS <b>John J. Little, Sr.</b>	

HISTORICAL DATA		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		POST-MORTEM FINDINGS		GROSS FINDINGS		MICROSCOPIC FINDINGS			
History of Present Illness: <b>On Dec. 12, 1952, patient experienced chest pain and discomfort, which increased in severity and was associated with sweating and nausea. He died at home on Dec. 13, 1952.</b>		Physical Examination: <b>On Dec. 12, 1952, patient was found to be pale, anxious, and in distress. He had a rapid, irregular pulse and elevated blood pressure. He died on Dec. 13, 1952.</b>		Laboratory Examinations: <b>On Dec. 12, 1952, patient had a blood glucose level of 120 mg. per 100 ml. and a serum cholesterol level of 250 mg. per 100 ml. He died on Dec. 13, 1952.</b>		Post-Mortem Findings: <b>On Dec. 13, 1952, patient was found to have a large, firm, and pale heart. The heart was enlarged and the myocardium was infarcted. He died on Dec. 13, 1952.</b>		Gross Findings: <b>On Dec. 13, 1952, patient was found to have a large, firm, and pale heart. The heart was enlarged and the myocardium was infarcted. He died on Dec. 13, 1952.</b>		Microscopic Findings: <b>On Dec. 13, 1952, patient was found to have a large, firm, and pale heart. The heart was enlarged and the myocardium was infarcted. He died on Dec. 13, 1952.</b>		Microscopic Findings: <b>On Dec. 13, 1952, patient was found to have a large, firm, and pale heart. The heart was enlarged and the myocardium was infarcted. He died on Dec. 13, 1952.</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14272

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14267

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>8 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>1431 GUILFORD AVE.</b>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First <b>BERNARD</b> Middle <b>CALVIN</b> Last <b>YOUNGBLOOD</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>11</b> Year <b>59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/1920</b>	9. AGE (In years last birthday) <b>39</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRIC CONTRACTOR</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. YOUNGBLOOD</b>				14. MOTHER'S MAIDEN NAME <b>EMMA WALTERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>214-05-6495</b>		17. INFORMANT <b>MRS. NELLIE C. YOUNGBLOOD</b> Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cerebral Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> (c) <b>Recent</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dr. E. W. J. J. J.</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FREED, J. J.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/14/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>DAVIS MEM. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CUMBERLAND MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Harment, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 10/57

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14296

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14381

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>	c. LENGTH OF STAY IN 1b <b>9Yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock Maryland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		d. STREET ADDRESS <b>/</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>David</b> Last <b>Zepp</b>		4. DATE OF DEATH Month <b>12</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2.15.1914</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Liquor Store</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Liquor Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore City Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Zepp</b>		14. MOTHER'S MAIDEN NAME <b>Lena Renke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213.12.7920</b>	
17. INFORMANT <b>Margie L Zepp Hancock Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Myocardial Infarction</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arrested tuberculosis 002X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>4:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank B Thomas III M.D.</b>		ADDRESS (Street, city or town, state) <b>121 High Street</b> DATE SIGNED <b>Jan. 2, 1960</b>	
PHYSICIAN'S NAME (Type) <b>Frank B. Thomas III M.D. Hancock, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1.3.59</b>	22c. NAME OF CEMETERY OR <del>REPOSITORY</del> <b>Presbyterian</b>	22d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Johnson Hancock Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



